Alberta Health Services

ANNUAL REPORT

2011-2012

Alberta Health
Services

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Alberta Health Services

LETTER OF ACCOUNTABILITY

We have the honour to present the annual report for Alberta Health Services for the fiscal year ended March 31, 2012.

This annual report was prepared under the Board's direction, in accordance with the *Government Accountability Act*, *Regional Health Authorities Act* and directions provided by the Minister of Health and Wellness. All material economic and fiscal implications known as of June 7, 2012, have been considered in preparing the Annual Report.

Respectfully submitted on behalf of Alberta Health Services Board,

"Original Signed by Catherine Roozen"

Catherine Roozen
AHS Board Chair

WELCOME TO THE 2011–2012 ANNUAL REPORT

The past 12 months have been a time of progress and improvement for Alberta Health Services. We continued to build on the stability and direction provided by the 5-Year Health Action Plan and the Government of Alberta's five-year health funding commitment. We laid the groundwork for growth, and redoubled our effort to create the progressive, responsible, patient-focused health system Albertans say they want. We recognize every community in Alberta is unique and, as such, we restructured to ensure decisions are made closest to where care is provided. Today, our five zones have much greater decision-making and accountability using a structure that draws equally from clinical and operational leadership, and encourages greater community engagement through our Health Advisory Councils.

With our renewed focus on patient care, most performance measures are trending in a positive direction. Length of stay in our emergency departments is down. Wait times for many surgeries are down. There are more continuing care spaces across the province and significantly more seniors are benefiting from care in their own homes. We still have much work ahead, but it is clear we are well beyond talking about what needs to be done and are actually getting it done.

We remain focused on how best to take care of Albertans, at every age, in every community, and remain committed to being open and transparent. I am confident we are taking the right steps that will add up to great strides in health care.

"Original Signed by Dr. Chris Eagle"

Dr. Chris Eagle
President and CEO

Alberta Health Services is structured around three key goals which include Quality, Access and Sustainability. These three goals are interconnected and need to work together. Our success will be measured by the health and wellness of Albertans, their ability to access the system and our ability to meet these goals in a sustainable manner.

- **Quality:** health care services are safe, effective and patient-focused
- **Access:** appropriate health care services are available
- **Sustainability:** health care services are provided within available resources both now and into the future

The following stories illustrate some of the accomplishments and progress that have been made over the past year. There are truly an unlimited number of achievements in patient care by the individuals and teams that deliver and support health care in this province. The stories are grouped into six priority areas which in combination have advanced our goals of Quality, Access and Sustainability.

Improve Access and Reduce Wait Times

We are committed to providing quality health care for Albertans, at the right time, in the right place. We have made positive strides in decreasing wait times and improving access to that care in many areas. This section provides a view of some of the ways that transformation is taking place.

Seniors

Providing more choice and adding more continuing care spaces throughout Alberta is part of a five-year plan to meet the needs of Alberta's aging population. Often this means helping seniors remain in the comfort of the home, safely. We have also found innovative ways to provide health care to our seniors, with more convenience and comfort.

Primary Care

Primary care is a patient's first point of contact with the health system and we know that stronger primary care leads to better health outcomes. Alberta Health Services is supporting primary care services by providing care and resources to help Albertans manage and improve their health. Important focus has also been placed on addiction and mental health services, which have been highlighted through some of the stories included in this report.

Wellness

Alberta Health Services is working to inspire and create opportunities for learning, health and healing. Promoting wellness in our population is about more than preventing illness. It's about supporting Albertans to achieve the best health possible by building mental, physical, social and spiritual well-being.

Enabling One System

It's a great responsibility and a daunting task to serve 3.8 million Albertans over 661,848 square kilometres. As the largest health care organization in this country, AHS has reached our three-year milestone. In that time, we have worked to create systems that support our staff and physicians in delivering the highest standards of care to our population. These stories show how Alberta Health Services has been finding strategic and efficient ways to work as one system.

Research and Technology

Exciting health research is taking place in this province that is making a difference in the lives of Albertans today and changing the course of how illness and disease will be treated in the future. We are also fortunate to have unprecedented access to new technology in this province. Examples of both of these areas are highlighted in this section of our Annual Report.

QEII trauma team members in Grande Prairie, from left: Karen Seymour, Jeannette Cochrane, Dr. Tom Peebles, Dr. Richard Beekman, James Moffatt and Candice Keddie.

New Trauma Team Ready for Action

A newly formed team of health professionals equipped with trauma medical equipment is now immediately available when trauma patients arrive by ambulance to the QEII Hospital emergency department.

This new initiative, launched this past August at the Alberta Health Services (AHS) facility, can trigger the mobilization of a specialized trauma team while the patient is being transported by Emergency Medical Services (EMS). When the patient arrives, trauma care is immediate.

The trauma team can include various medical specialists, depending on the nature of the injuries, but always includes a radiologist, who ensures a CT scanner is ready for the patient; laboratory staff, who gather at the

emergency entrance ready to take blood samples; and a respiratory therapist, who can quickly clear possible blockages in the patient's airway. The team also includes a co-ordinated effort between the emergency physician and the general surgeon.

"It puts everyone in place to decrease delays in care," says Dr. Richard Beekman, former medical director of the Facility Trauma Program at the QEII Hospital.

Trauma patients have multisystem injuries, such as a head and chest injury, or chest and extremities, or some other combination, which are caused by sudden physical impact. The QEII treats between 80 and 100 trauma patients every year.

Previously, decisions about staff and equipment would be made upon a trauma patient's arrival. The delivery of care was prompt, but there was room for improvement.

Now the newly developed provincewide Trauma Team Activation Guideline, aligned to Trauma Association of Canada standards, outlines the health professionals and equipment needed for specific trauma cases in order to eliminate all possible delays in the delivery of health care.

EMS personnel contacts the emergency department and provides information about a trauma patient during transport. That information can trigger staff to put a trauma team in place.

New Emergency Department Opens at Stollery

In February 2012, the Stollery Children's Hospital opened the doors to its new pediatric emergency department, Edmonton's first emergency department (ED) dedicated to pediatric and family-centred care. The $26.3-million renovation expanded and separated the Stollery's emergency department from the University of Alberta Hospital.

The Government of Alberta contributed $21.2 million to the project; the other $5.1 million came from the Stollery Children's Hospital Foundation.

The space provides a separate ambulatory entrance for patients and their families, along with a separate child-friendly waiting room, triage area and registration area. A new family consultation room, enhanced work space for pediatric emergency physicians and a trauma room will open in late 2012. About 1,240 square metres—13,350 square feet—of space was added to the existing department.

In 2011, nearly 28,000 pediatric emergency department visits were made to the Stollery, more than double the 12,000 visits recorded when the ED opened 12 years ago. The new ED is built to accommodate up to 35,000 visits per year based on appropriate staffing capacity.

Dr. Bruce Wright and his children, Griffin and Scarlett, along with triage registered nurse Leanne Foff, role-play in a mockup triage exercise prior to the Stollery emergency department opening.

Teamwork: registered nurse Sherryl Park, left, cardiologist Dr. Michael Chan, heart-failure patient Bob Hoskins and nurse practitioner Jennifer Halenar celebrate Hoskins's success at the CK Hui Heart Clinic in the Royal Alexandra Hospital.

Access to High Demand Specialized Services Builds Across Alberta

Access to surgery improved on several fronts across the province as Alberta Health Services worked to grow capacity and trim wait times this past year.

Highlights include more than 2,600 additional cataract surgeries performed in Calgary, Edmonton, Lethbridge, Wetaskiwin, Lamont, Red Deer and Grande Prairie to help reduce wait lists for this procedure, raising the yearly total to more than 36,000 eye surgeries provincewide.

"Adding surgical capacity in high-demand areas is a key priority for AHS," says Dr. Chris Eagle, President and Chief Executive Officer of Alberta Health Services. "These additional procedures will enable more Albertans to have their cataract surgeries done in a timely manner."

"Headway is being made on boosting the number of elective total hip and knee replacement surgeries," says Dr. Don Dick, clinical co-director of the Bone and Joint Strategic Clinical Network (BJSCN), with its program to reduce length of stay in acute care to four days for most patients.

"Acute care stay has ranged from 10 days to three-and-a-half days at hospitals across the province," says Dr. Dick. "Reducing length of stay to four days — the benchmark for Alberta — is freeing up hospital beds, allowing more surgeries to be performed."

"The BJSCN realized some major successes in 2011-12. Bed-day savings are projected to free up substantial bed capacity for additional surgeries," adds Dr. Dick.

At the same time, AHS doctors performed approximately 1,200 additional hip and knee replacements in 2011-12. These were carried out at surgical sites across the province, with many of them performed at the Orthopedic Surgical Centre in Edmonton and the McCaig Tower in Calgary, both new facilities that are hitting the four-day target. The cost of these surgeries was partly offset by

the efficiencies from the reduced hospital stays.

Meanwhile, referral times for heart-failure patients have fallen by 75 per cent — to two weeks from eight weeks — over the past two years at heart function clinics at the CK Hui Heart Centre and the Mazankowski Alberta Heart Institute in Edmonton.

"The clinic gave me great hope," says patient Bob Hoskins, 61. "I was treated like I was the only person in the hospital, with great respect and dignity and understanding of my situation. Since then, my heart function overall has improved, putting me very close to the normal range. I've been discharged from the clinic. It's a success story."

Credit for the shorter referral times goes to the May 2011 opening of the state-of-the-art CK Hui Heart Centre, increased capacity at the Mazankowski, a restructured patient intake process at both hospitals and improved collaboration between all health care providers.

Growing Nurse Practitioner Role a Plus for Patients

The increasing role of nurse practitioners (NPs) on health care teams has fostered improved access, reduced wait times and comprehensive patient care.

"More nurse practitioners now have their own outpatient clinics," says Christene Evanochko, a nurse practitioner professional practice leader in Edmonton. "We're not physician replacements. We're nurses who can do additional duties, who are specially trained and licensed. We collaborate very much with the physicians."

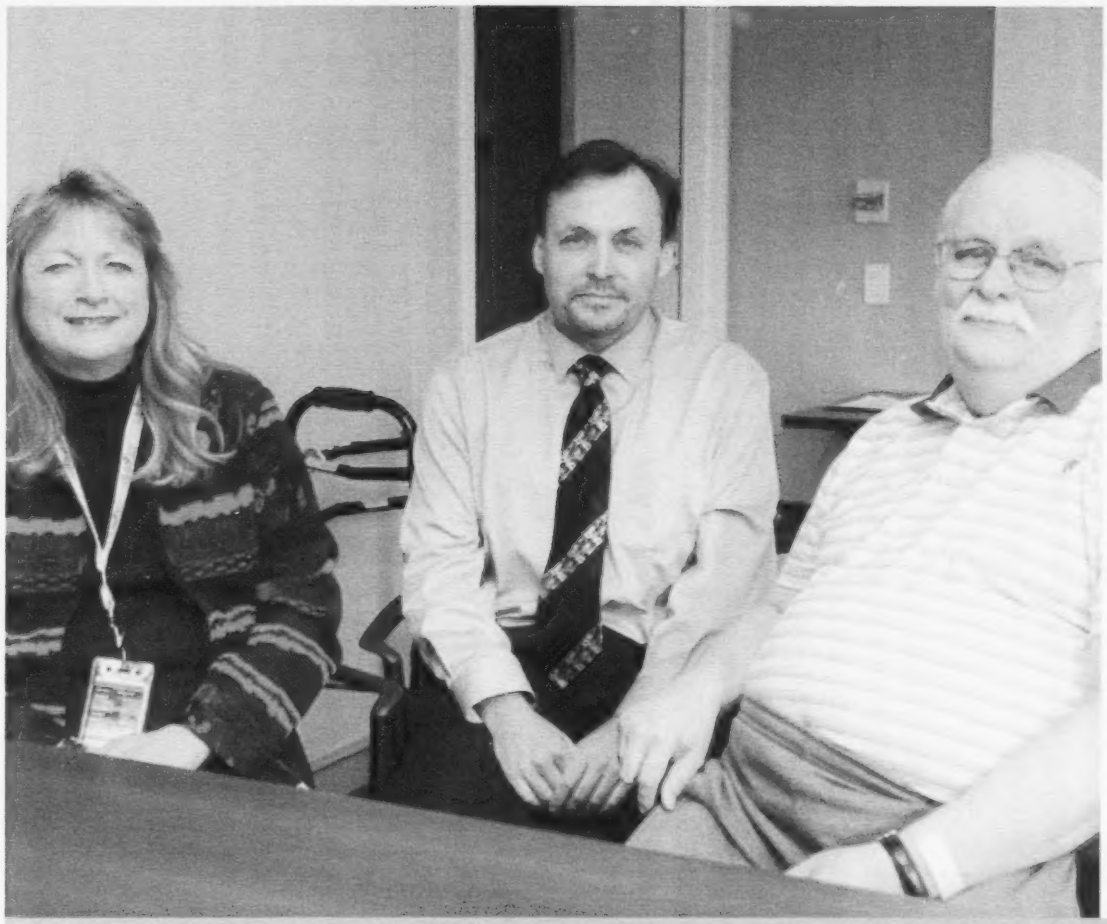
"These days, I feel really, really good," says Margaretha Salamon, 78, a patient of NP Jissy Thomas of the Cardiovascular Risk Reduction Clinic at the Mazankowski Alberta Heart Institute. "I'm just tickled pink with Jissy's care. I followed her plan and today she tells me I'm her healthiest patient."

In Edmonton hospitals, 26 NP-led clinics were piloted in early 2011 and made permanent in July. In nearby Vermilion, a NP now offers family practice care to the community.

In Calgary, 10 NPs manage clinics while three others serve on the neurosciences team at Foothills Medical Centre. NPs also play key roles at rural and community facilities (Nanton), specialty clinics, integrated seniors health and primary care (Cochrane, Airdrie and Okotoks). Across the North Zone, nurse practitioners now offer a wide spectrum of primary care and other community services at seven clinics. In the South Zone, an NP serves a unique role on the Brooks Home Care Team, improving access to care and reducing ED visits and EMS calls for frail home care clients. As well, primary care networks in Taber and Lethbridge have integrated NPs on their clinic teams. Across the province, more NPs are being recruited for family care clinics – a new model of primary health care which offers individuals and families access to a team of health care professionals and services.

Nurse practitioner Jissy Thomas counsels patient Margaretha Salamon, 78, on keeping up her healthier lifestyle. Thomas oversees the Cardiovascular Risk Reduction Clinic at the Mazankowski Alberta Heart Institute.

Outpatients can book appointments directly with the nurse practitioner for initial assessments, treatment, care and follow-up. Of the 321 nurse practitioners in Alberta, 229 work for AHS.



From left, volunteer Lori Beaver and Dr. Andrew Demchuk, director of the Calgary Stroke Program, visit patient Tom Moore, who recently had a stroke and appreciates the encouragement he receives through the peer support program.

Peer Support Program Inspires Stroke Patients

Tom Moore's life changed forever this past September.

"At first, I couldn't believe I was having a stroke," the 64-year-old Calgary man recalls. "When I couldn't move my left leg, I knew it was real."

Suffering a stroke is often a confusing time for patients and their families. However, a new peer support program offered at Foothills Medical Centre in Calgary is helping recent stroke patients like Moore take new steps on their road to recovery.

INSPIRES (Inpatient Support Program In Recovery from Stroke) allows volunteers who have had a stroke and are recovering and coping well to share their knowledge and experience with patients who recently suffered a stroke. The program, developed by the Calgary Stroke Program in April 2011, is the first of its kind in Alberta.

"If you can meet somebody who's gone through this before, it shows there's hope. It's helped me to celebrate the small triumphs through my recovery," says Moore.

"Talking about it definitely helps."

During visits, patients and their families have the chance to share their stories and concerns, and also hear from volunteers who share their experiences.

"Patients are often terrified – one day their life is normal, the next day they're paralyzed and can't speak or remember things," says stroke survivor and volunteer Lori Beaver.

"They're thankful for a visit. It shows them that there can be life after a stroke."

Dr. Andrew Demchuk, director of the Calgary Stroke Program, says depression is common following a stroke, and speaking with another stroke survivor may decrease the likelihood of depression.

"When you have a stroke, the fear is that you're not going to recover enough to regain your independence," Dr. Demchuk explains. "It's inspiring to meet someone who's gone through it and recovered, or at least learned to cope with their new limitations."

Coming Together for Slave Lake

Wildfires brought destruction to much of the town of Slave Lake on the weekend of May 14–15, 2011.

The fires forced the evacuation the town's residents, as well as patients and staff at the Slave Lake Healthcare Centre, and the Slave Lake Addiction office on May 15.

Alberta Health Services staff members and physicians put aside their own concerns for the safety of their families and personal property to bring forth a remarkable team effort.

A number of sites took in Slave Lake patients and long-term care residents when the need arose, and staff from Public Health, Environmental Public Health, and Addiction and Mental Health responded quickly to the need to support thousands of community members at evacuation and reception centres set up in Athabasca, Peace River, High Prairie, Wabasca, Westlock and Edmonton.

Emergency Medical Services (EMS) provided both the quick evacuation of the hospital to a temporary location in the town and then the transfer of those patients to a location outside Slave Lake. The provincial system and consolidation of EMS dispatch helped facilitate this smooth evacuation.

As well, after the town had been completely evacuated, EMS provided the primary care for all emergency workers and other people until temporary facilities were in place. Support services such as Administrative Support and

As wildfires ravaged Slave Lake, Alberta Health Services staff sprang into action, ensuring the 29 patients in the Slave Lake Healthcare Centre were evacuated.

Contracting, Procurement and Supply Management also played a big role in supporting emergency response needs and recovery efforts at the facility.

The Slave Lake Healthcare Centre, which sustained smoke damage from the fire, reopened May 25 with health clinic services operating out of the emergency department. The facility resumed full operation about a month later.

Radiation vaults provide radiation therapy for lung, breast, prostate and colorectal cancers.

Lung Cancer Patients Benefiting from Stream-lined Care

Lung cancer patients now benefit from faster access to treatment thanks to new specialized 'rapid access' clinics in Edmonton and Calgary and a boost in the number of lung cancer surgeries performed each year.

The Expedited Management of Lung Cancer Program aims to ensure that, by March 2013, 75 per cent of patients will wait no longer than 30 days from the time of referral from their primary care physician to when a treatment decision is made, and 60 days from the time of referral from their primary care physician to surgery.

As well, 184 additional lung cancer surgeries will be performed in Edmonton and Calgary each year, for a total of about 1,600 per year across the province, a 13 per cent increase.

Two newly created rapid access clinics, operating in tandem in Edmonton and Calgary, now provide a single point of entry for all patients. Specially trained nurses and nurse practitioners, with physician support, assess and triage patients and then navigate them through the many diagnostic tests needed before a treatment decision can

be made. About 4,000 patients a year are expected to be referred to the clinics by 2013.

Previously, patients could be referred to a range of specialists located throughout the province, which would increase the time needed to perform tests and make treatment decisions.

Dr. Paul Grundy, acting senior vice president, Cancer Care, says early diagnosis and treatment of lung cancer is a priority for AHS. "This program tackles the issues that can potentially delay treatment and applies solutions consistently across the province," he says.

The AHS Cancer Care Clinical Network, a team of highly experienced cancer doctors and managers, worked with a range of experts — surgeons, respiratory specialists, radiologists, family doctors, nurses and oncologists — to establish the program, the first co-ordinated, provincewide initiative of its kind for lung cancer in Canada.

Other program highlights include: an additional 1,300 diagnostic bronchoscopies (lung examination and biopsy) will be performed each year, for a total of 3,150 (a 70 per cent increase); and an additional 500 CT-guided biopsies for lung cancer will be performed each year, for a total of 1,582 (a 46 per cent increase).

Radiation Therapy Care Offered Closer to Home

Alberta's Radiation Therapy Corridor is one of the most significant developments in the ongoing expansion of cancer care.

In the past, cancer patients needing radiation treatment had to travel to Edmonton or Calgary. Now, residents of southern Alberta can be treated at the Jack Ady Cancer Centre in Lethbridge, and residents in central and northern Alberta will have similar access to radiation therapy once construction of facilities is complete in Red Deer and Grande Prairie.

"The Radiation Therapy Corridor will save precious travel time for patients," says Brenda Hubley, operations lead, Radiation Treatment Corridor. "We estimate the number of Albertans having to travel 100 kilometres or more to receive treatment will be reduced from 28 per cent to eight per cent."

The program is already making a difference. The 2010 opening of the Jack Ady Cancer Centre has provided radiation treatment for some 600 southern Albertans. Meanwhile, the Central Alberta Cancer Centre in Red Deer is scheduled to open in early 2013, and another cancer centre in Grande Prairie in 2015.

Cancer patients in southeastern Alberta will, for the first time, have access to the latest, experimental drug therapies through the Margery E. Yuill Cancer Centre in Medicine Hat. Linda Glasier and Brian Bay were on hand in September 2011 for the renaming of the Margery E. Yuill Cancer Centre. Both have battled cancer and have received treatment there.

Through the CHAPS program paramedic Ryan Courtney can help people like Betty Carson connect with community supports to help maintain independence.

EMS Connects Patients with Community Supports

Through the Community Health and Pre-hospital Support (CHAPS) program, Emergency Medical Services (EMS) staff are able to identify patients living in the community who may be at risk to have their health deteriorate due to hazards or lack of supports in their home.

Patients are then connected with existing programs and services, such as home care, to help maintain their independence and ability to remain safely in their homes.

"When we respond to a call at a patient's house, we have an opportunity to see their living environment and observe their home surroundings," says Kent Riddle, manager, EMS Health Integration. "We are able to see hazards and areas where they might need a little extra assistance."

EMS crews are able to identify if there are tripping hazards in the home that might cause future falls or if the patient is unable to properly maintain their housekeeping. These are some signs that the patient could be struggling to maintain their independence.

The goal of the program is to reduce the number of repeat EMS calls, visits to the emergency departments and admission to the hospital, by connecting these patients to community-based health and support services.

Once the EMS crew identifies someone at risk, they forward their information to a patient navigator who then works as a liaison with the appropriate community-based program for assessment and follow-up.

"There are many community supports available, but knowing how to access them can be complex. In essence, we are acting as guides to help connect these people with the right resources to provide early intervention, which should ultimately lead to improved outcomes," says Riddle.

The patient navigator works closely with Community Care Access to arrange for a more complete assessment to identify specific needs.

The CHAPS program began as a trial program focusing solely on seniors and their risk of falling. Building on the success of the initial trials, the program was expanded to encompass anyone at risk and was rolled out provincially in January 2012.

Coordinating a Team-Approach to Seniors' Care

Alberta Health Services', Continuing Care Case Management Framework & Guidelines were introduced early in 2011 as a new initiative to guide and standardize case management practice in continuing care facilities.

Case management is an essential component of an integrated health system, ensuring access to appropriate care and services. Each person admitted to a continuing care facility is assigned an Alberta Health Services case manager who provides leadership in collaborating with the interdisciplinary team, ensures continuity of care, and facilitates integration across the continuum of health and community-based services.

A case management calendar was developed as an educational tool and distributed to staff in December 2011. Highlighting the 11 case management principles outlined in the framework, the calendar helps guide Alberta Health Services case managers to use a person-centred approach when supporting individuals to achieve their health goals.

Staff from St. Therese Villa (Covenant Health in Lethbridge) and AHS Home Care work together to provide support to seniors in continuing care.

Alberta Health Services

AHS is providing seniors with more options to remain safe, healthy and independent.

Continuing Care Options Expanding for Alberta's Seniors

Alberta Health Services, in collaboration with Alberta Health and Wellness and Alberta Seniors and Community Supports, opened 1,002 new continuing care beds in the 2011-12 fiscal year.

Providing more choice for continuing care, and adding more continuing care spaces throughout the province between 2010 and 2015, are among the goals outlined in the 5-Year Health Action Plan, jointly developed by the Government of Alberta and AHS.

"Seniors have told us they want to live in their own

communities as long as possible," says David O'Brien, AHS vice president, Seniors' Health. "Providing a range of living environments coupled with community and site-based health services is a key strategy to meet this request."

More seniors and adults with disabilities are able to remain safe and independent in their own homes as AHS added nearly 4,400 home care clients, an increase of 4.4 per cent, exceeding our target of 3,000 additional clients by March 2012.

The opening of the Good Samaritan Linden View facility in Taber in July 2011 is one example of the new facilities coming on stream. The 105-bed residential facility provides accommodation for people who need supportive living, some of whom live with dementia. Beds are also reserved for those who need palliative care, respite or convalescence.

"We have been working hard to build more supportive living capacity because that's what seniors want and need," O'Brien says.

Technology Boosts Home Care for Diabetics, Seniors

A new research project is giving Sherwood Park-area diabetics, many of whom are seniors, the technology to have their blood-glucose levels monitored remotely by doctors and health professionals.

Lola Drew, 74, loves new technology that helps her medical-care team keep an eye on how she's doing, without her having to leave her living room.

"By going on my computer, I can see by the graph that my blood sugars are up or down," Drew says. "I don't have to go anywhere."

Drew has Type 2 (adult-onset) diabetes and joined a first-in-Alberta research project when it launched in summer 2011. The technology has made managing her chronic condition easier and more convenient.

In the first phase of the project, 30 diabetics entered their daily blood-glucose readings into their online personal health record via a secure Internet connection, allowing physicians, nurses and home care professionals to monitor them.

Lola Drew, 74, a participant in a remote-glucometer research project, points to a graph of her blood-sugar levels online.

The next phase of the project, which started in early 2012, simplifies the process. Glucose readings are automatically transmitted into the health record by wireless glucometers, or ones that connect directly to a computer.

Aboriginal Youth and Communities Empowerment Strategy (AYCES) conference aims to help the province's aboriginal communities actively promote suicide prevention. Shown in this photo, left to right: Warren Winnipeg, former coordinator of the AYCES program; Rhonda King-Blood, health promotion specialist; Treena Tallow, AYCES coordinator

Empowering Aboriginal Teens

More than 70 aboriginal elders, parents and youth gathered at a two-day forum in October 2011 to discuss strategies to improve the self-esteem of children in their communities and bring down the rates of teen suicide.

Alberta Health Services hosted the fourth Honouring Life: Aboriginal Youth and Communities Empowerment Strategy (AYCES) conference, where health professionals listened closely to participants to determine how existing services can be improved as well as to identify needs for new programs.

Delegates also included representatives from Alberta Health and Wellness, First Nations Inuit and Aboriginal Health and the Metis Nation of Alberta.

"Giving power to that word suicide makes a big impact," Hobbema community justice leader Luci Johnston told the gathering. She prefers a Cree term her community came up with in their struggle to deal with teen suicide, "Mamowoketeyowitan" which means "let's grow old together."

Alberta Health Services priorities include finding new ways to help Alberta's aboriginal youth feel balanced, healthy, hopeful about their lives, proud of their cultural identities and confident in pursuing success.

Launched in 2005, AYCES aims to help the province's aboriginal communities actively promote suicide prevention.

Today, AYCES — in partnership with AHS — delivers a wide range of programs in aboriginal communities across Alberta. AYCES funding reaches at least 24 First Nations, Metis and urban aboriginal communities and organizations.

Some of these programs encourage aboriginal youth to discuss mental wellness, substance abuse and violence; provide work experience and employment opportunities; and promote educational opportunities and healthy lifestyles.

Creating better connections between the community and mental health services is also a priority in the Government of Alberta's new Addiction and Mental Health Strategy.

Many forum participants either deliver or benefit from these programs, and their input and feedback was crucial to improve these services, says Dr. Michael Trew, senior medical director for AHS Addiction and Mental Health.

"The risk of death by suicide is not just a health care problem," says Dr. Trew. "Teen suicides are a tragedy for which we are all accountable; it is a societal problem with no single solution and there are many factors that can help. This conference highlights some of the solutions."

Suicide rates among aboriginal youth in Alberta are about 10 per cent higher than among non-aboriginal youth.

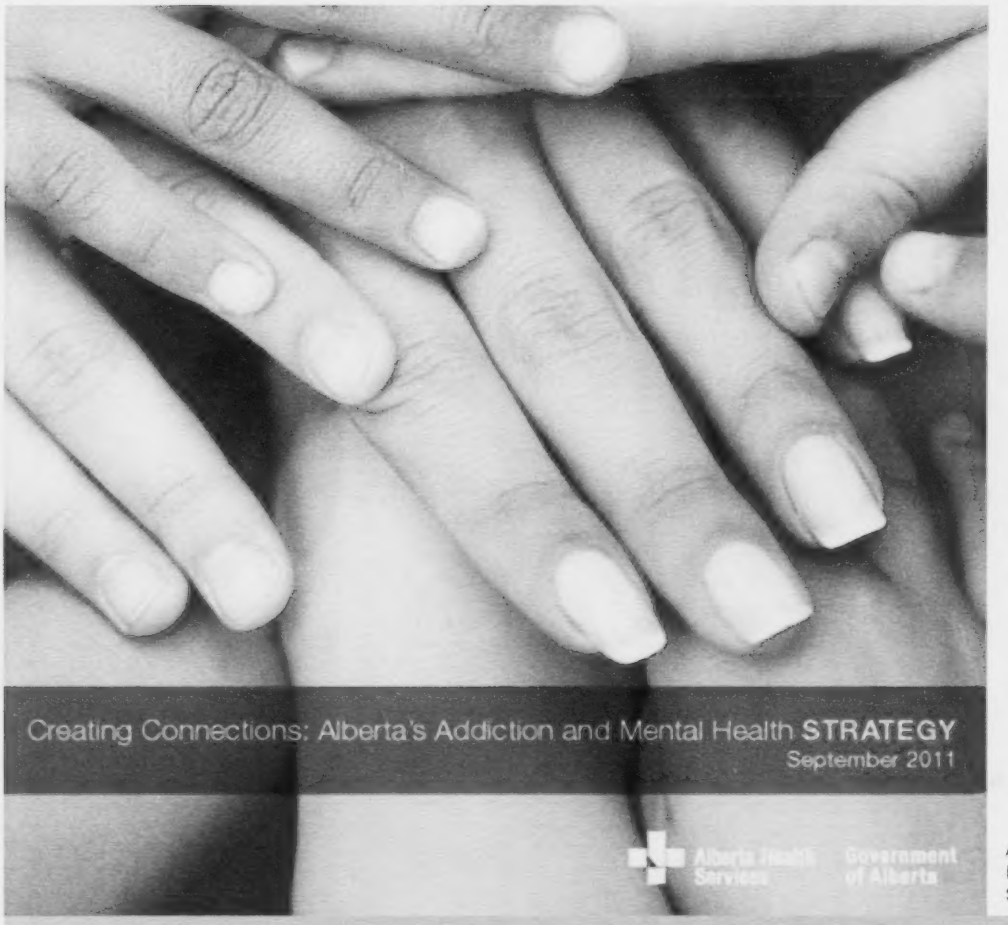
More Albertans Butting Out

More Albertans than ever before had local access to a free tobacco cessation program to help them butt out this past year, following the expansion of the successful QuitCore program.

QuitCore is a key component of Alberta Health Services' Tobacco Reduction Programs' cessation framework and was offered in 13 new communities for the first time in January 2011. It is now offered in more than 20 communities across the province for tobacco users looking to quit.

The Winter 2012 sessions saw the program not only expand to new communities, but also to new partners, as four of the sessions were run in partnership with primary care networks.

Led by trained cessation professionals, the QuitCore program teaches tobacco users how to develop a plan to quit that will work for them, while providing strategies to deal with recovery symptoms, manage stress and prevent relapse.


Creating Connections: Alberta's Addiction and Mental Health STRATEGY
September 2011
Alberta Health Services
Government of Alberta

Alberta's Addiction and Mental Health Strategy was unveiled in September 2011.

Creating Connections

Each year, more than 500,000 Albertans receive at least one mental health service from a physician. And each year, alcohol abuse costs Albertans millions of dollars in lost productivity, direct health care costs, and law enforcement.

The human toll of mental illness and addiction is even more costly. But now, a new Alberta strategy sets out a blueprint for creating a seamless system to ensure the best quality assessment, treatment and support services are available to Albertans – where and when they need them.

"The real strength of the new strategy is the collaboration between many different government departments and community agencies," says Nancy Fraser, AHS Addiction and Mental Health executive director. "It will make a significant difference in the lives of individuals and their families."

Unveiled in September 2011, Creating Connections: Alberta's Addiction and Mental Health Strategy, was developed by Alberta Health and Wellness and Alberta Health Services. It involved 16 Government of Alberta

ministries in recognition of the fact that many people with addiction and mental health issues are served by many government departments.

The strategy has five key directions:

- To build healthy and resilient communities by focusing on health promotion and illness prevention and improving access to primary health care;
- To foster the development of healthy children, youth and families by improving access to a full continuum of services;
- To enhance community-based services, capacity and supports, including addressing housing and rural capacity;
- To address complex needs so that Albertans requiring specialized or co-ordinated care have access to a full range of appropriate addiction and mental health services;
- To enhance assurance in the system by developing appropriate oversight policies, structures and initiatives so Albertans can be confident in service quality and client safety.

Some programs and services supporting the strategy are already underway throughout the province. They include adult depression program pilots in primary care networks, aboriginal youth suicide prevention programs, discharge planning for the homeless, inner city and rural police crisis teams, Telehealth psychiatric services, access standards for children's mental health services, and many alcohol and drug reduction programs in schools, communities and workplaces.

A provincial Addiction and Mental Health Advisory Council was established to provide support and advice in the implementation of the strategy.

Primary Care Services Bolstered in La Crete

Access to primary care in La Crete received a big boost in 2011 when Alberta Health Services introduced advanced ambulatory care to the La Crete Community Health Centre.

The new advanced ambulatory care centre is now open seven days a week to provide timely diagnosis and treatment for urgent but non-life-threatening conditions, including sudden illness or injuries that can be normally treated in a doctor's office, but which require immediate attention.

Previously, La Crete residents needed to drive an hour to Fort Vermilion or two hours to High Level to access a similar service.

"A lot of planning and work has taken place to provide this in the community," says Sandra Herritt, AHS director of Community and Rural Hospitals, Northwest. "New health care staff were hired, additional equipment purchased and new operational processes developed to support the service."

Eva Friesen, left, and Mary Janzen, members of the La Crete Health Care Review Committee, cut a cake made to look like the new sign in front of the La Crete Health Centre.

Breast, Colon Cancer Screening Programs Save Lives

Early detection of breast and colorectal cancer is saving lives across the province thanks to two Alberta Health Services initiatives — Screen Test and the Alberta Colorectal Cancer Screening Program (ACRCSP).

Screen Test, Alberta's only mobile breast screening program, celebrated its 20th anniversary in 2011. To date the program has provided more than 196,000 mammograms for 67,000 women in 111 rural sites across the province.

"Screen Test is proud of our many achievements over the past 20 years," says Joan Hauber, manager, Screen Test. "Our staff work very hard to ensure that all Screen Test clients have the best mammography experience from the time of booking an appointment to receiving their results."

Screen Test is part of the Alberta Breast Cancer Screening Program (ABCSP), a provincial initiative with the Alberta Society of Radiologists that helps ensure as many women as possible benefit from early detection and treatment of breast cancer.

Co-ordinated by Alberta Health Services, the ABCSP supports women by providing up-to-date information about breast health and inviting women 50-69 years to participate in screening. The program also empowers women by informing them of their results and recommended next steps.

A screening mammogram can detect breast cancer up to two to three years before it would otherwise be detected by the patient or her doctor.

For the ACRCSP, key accomplishments of the past year include:

- Expanding screening-related colonoscopy capacity;

- Developing patient education resources and materials;
- Completing a demonstration project for a new entry-level stool screening test (fecal immunochemical test – FIT) in two primary care networks;
- Completing a new standardized reporting format for colonoscopy at seven rural facilities;
- Developing central intake and patient navigator functions;
- Working towards expanding patient result letter initiatives and ensuring quality in colonoscopy.

As well, the North Zone completed more diagnostic and screening colonoscopies in Grande Prairie.

The Central Zone is adding another endoscopy suite to support screening colonoscopies.

In the Edmonton Zone, new ACRCSP screening criteria have doubled the detection rate of pre-cancerous polyps.

In the Calgary Zone, establishment of the Colon Cancer Screening Centre (CCSC) has shifted colorectal cancer screening-related colonoscopies from the acute care hospitals to the CCSC, increasing acute care endoscopy capacity.

In the South Zone (Medicine Hat), the ACRCSP expansion has enabled the consolidation of endoscopist wait lists, resulting in more efficient patient intake and referrals.

Cervical Cancer Checks Protecting More Women

The Alberta Cervical Cancer Screening Program (ACCSP) now covers more women in Alberta, ensuring higher screening rates and better outcomes for those at risk of cancer, thanks to a partnership effort between Alberta Health Services, Alberta Health and Wellness and other service providers.

Co-ordinated by Alberta Health Services, the ACCSP is a population-based program that works in partnership with health care providers to engage women in screening, mail them their Pap test results, and remind women and their health care providers about overdue tests.

Population-based programs like the ACCSP increase the number of women who get screened and followed up appropriately, and decrease the number of women who develop and die from cervical cancer.

"Going through this type of screening process gives me a lot of peace of mind," says Edmonton's Jodie Hierlmeier. "We're often told early detection is the key to dealing with cancer and that certainly has been my experience with Pap test screening for cervical cancer."

Hierlmeier was referred to a cancer centre in 2006 after a regular pap test detected abnormal cells. A follow-up colposcopy confirmed she had adenocarcinoma in situ - a pre-cancerous condition. She underwent surgery to remove the abnormal cells. Today, she is cancer-free.

Jody Hierlmeier, left, an Edmonton woman who benefitted from cervical cancer screening, stands with Dr. Laura McDougall, medical lead for the ACCSP.

Previously, program services were being provided to women in the Calgary and South Zones. In 2011, a grant from the Alberta Cancer Prevention Legacy Fund initiated the program for women ages 21 to 69 living in the North, Edmonton and Central zones.

MEND program teaches families how to make healthy eating and active lifestyles their daily routine.Ty Jacobsen plays catch with MEND activity leader Brad Gregorchuk.

Obesity Initiative Targets Healthy Lifestyle

Albertans now have more support to maintain or move toward a healthy weight – including improved access to bariatric surgery – following the launch in 2011 of the Alberta Health Services Obesity Initiative.

The comprehensive, five-year plan is designed to help Albertans manage weight issues in a planned and co-ordinated manner and, at the same time, introduces a broad range of community-based services and programs to help prevent and treat obesity as early as possible.

Obesity is a chronic disease that affects about one million Albertans, or approximately 25 per cent of the province's population. It is linked to 22 other chronic diseases, including up to 90 per cent of all Type 2 diabetes, up to 30 per cent of cancers, and 80 per cent of cardiovascular disease.

"This initiative involves an integrated approach that recognizes the complexity of obesity prevention and management," says Dr. Arya Sharma, medical director of the AHS Obesity Initiative. "It increases our focus on preventing obesity in children, and improves obesity services in primary care."

For example, the MEND program (Mind, Exercise, Nutrition ... Do It!) is a free 10-week course running in eight different sites across the province, in which children ages 7 to 13, along with their parents, learn how to incorporate practical healthy eating and active lifestyles into their daily routine. It was launched in October 2011 and is being adapted for First Nations populations.

The Obesity Initiative will also feature new programming targeting adults who are ready to adopt a healthier lifestyle, such as lifestyle and nutritional support through community and primary care services.

Red Deer residents needing help with weight management received significantly improved access to a local bariatric clinic in the fall of 2011.

Approximately twice as many patients can now be seen annually at the bariatric clinic following the recruitment of two new bariatric surgeons and the relocation to an improved space within the Red Deer Regional Hospital Centre.

Vaccinations Boost Albertans' Health

If prevention is the best medicine, increasing delivery of the single most effective preventative measure against influenza can certainly be considered a shot in the arm for the health of Albertans.

In the 2011-12 influenza season, more than 874,000 doses of influenza immunization were administered across our province, a five per cent increase over the approximately 832,000 doses administered in 2010-11.

Alberta Health Services made it easier to get influenza immunizations this year, increasing the number of targeted outreach clinics for hard-to-reach vulnerable populations, as well as the number of public clinics available in many communities. More than 1,500 community partners—including many pharmacists and physicians— also offered the vaccine this season, increasing access to immunization.

As outlined in the 5-Year Health Action Plan, AHS is focused on increasing the uptake of influenza immunization as a means of reducing incidence— and health system impact—of this vaccine-preventable illness.

Kristin Rayner, admitting clerk, is getting a shot from Betty Neumeister, public health nurse.

A fresh, snappy roadshow format has put some fun into Workplace Health and Safety (WHS) educational sessions and motivated staff at Devon General Hospital. From left: Erika Stelmach, administrative assistant; Ann Martin, site manager; and Lorraine Nicolas, community liaison and WHS lead.

Devon Devises Fun, Fresh Roadshow to Promote Safety

Learning how to read hazard labels and keeping current on the handling procedures of noxious chemicals can make for a dry, lengthy Workplace Health and Safety (WHS) classroom session.

Remarkably, over the past year, Devon General Hospital has fashioned a fresh, snappy and fun roadshow format for safety-education sessions that has scored high attendance, motivated staff and inspired team-building.

Caring for this community of 6,500, located a 15-minute drive southwest of Edmonton, this 24-bed facility (13 hospital beds and 11 long term care beds) serves as home base to more than 100 Alberta Health Services physicians and staff.

The fact that the first four sessions — Hazard Identification, Assessment and Controls Awareness; Incident Management Awareness; WHS Awareness; and Workplace Hazardous Material Information System (WHMIS) Awareness — enjoyed the attendance of close

to 90 people reflects the positive energy that went into their creation.

"We have always had a strong affinity, a strong belief, in workplace health and safety," says site manager Ann Martin. "In the past, with our in-service sessions, however, we've always wondered: 'How come nobody comes?' And when they do come, 'How come they don't pay attention?'"

"By changing the format into a 20-minute roadshow, and making it fun, interactive and specific to departments, we find we can now talk about the things that really happen in their workday," adds Martin. "On any given day and shift, for example, we may have 35 people working — so when 26 of them show up for a roadshow, that's really good."

"We're taking what can be pretty dry subjects — like hand hygiene — and presenting them in a way that gets people to come," says Lorraine Nicolas, community liaison and WHS lead for Devon General Hospital.

"You can make it fun. We like to laugh. In those 20 minutes, we begin by saying, 'OK, this is a boring subject. Looking at labels is a pretty boring subject, right?' "

Participants then enjoy some brief teaching, some one-on-one with Nicolas or hospital educator Donna Saniga, followed by dialogue with their colleagues, a quiz and evaluation.

"Sometimes there are prizes, too, like chocolate bars or gift cards," adds Martin. "It works."

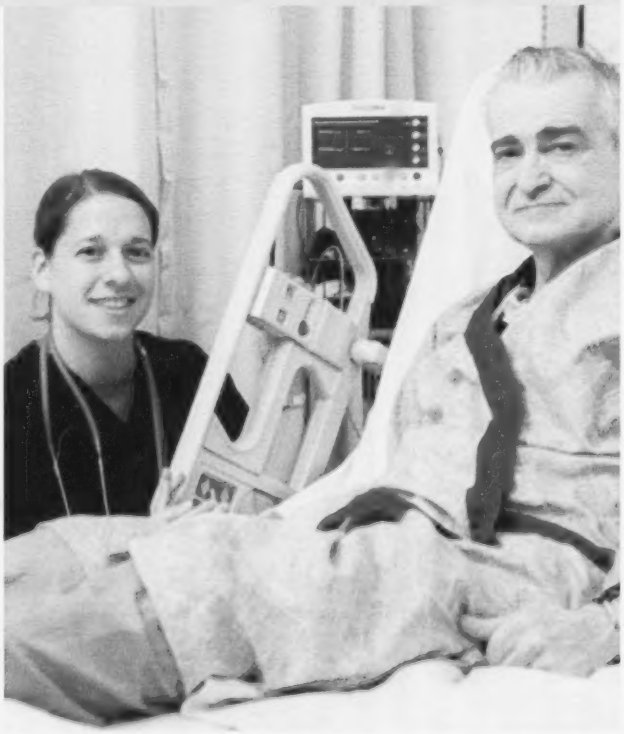
Re-shaping Health Care Delivery

Strategic Clinical Networks (SCNs) are engines of innovation bringing together physicians, clinicians, patients, researchers, staff and partners across Alberta to develop evidence-based strategies to improve patient outcomes and satisfaction, access to health care and sustainability of our health care system.

Growing the previous Clinical Networks into SCNs has allowed Alberta Health Services to expand the mandate for the networks, provide more support and ensure greater alignment to the zones and the business-planning process.

Each SCN will focus on a particular population and six SCNs have been identified and started work in January 2012: Obesity, Diabetes and Nutrition; Seniors' Health; Bone and Joint Health; Cardiovascular and Stroke Health; Cancer Care; and Addiction and Mental Health.

The excellent work done by the Emergency, Surgery and Critical Care Clinical Networks transitioned to Operational Clinical Networks, which touch on and support all SCNs. Orientations were held in 2011 and early 2012 to educate team members already in place, including the senior medical directors for each of the six SCNs.



Strategic Clinical Networks are engaging health care professionals and patients to improve patient outcomes.

AHS's staffing resources include a cross-section of health professionals. Shown here, clinical and allied health professionals from the Peter Lougheed Centre in Calgary: (clockwise from left) Iranjit Shokar, health care aide student, Angela Young, occupational therapist, Hilary Mcdermott, physiotherapy student and Stacey Israelson, registered nurse, Kamlesh Lata, licensed practical nurse and Carolina Villabroza, nursing attendant.

Rising to the Workforce Challenge

Alberta Health Services faces some complex challenges when it comes to making sure its workforce is adequately supplied with health professionals. Pending retirements, new facilities like Calgary's South Health Campus coming on stream, and shifting staffing demands brought about by policy changes all contribute to the complexity.

"The good news is that there has been net growth in the system," says Deb Gordon, senior vice president of Health Professions Strategy and Practice and chief nursing and health professions officer. "We have made progress in both the recruitment and retention of staff and are exceeding our forecast requirements in all our health professional groups.

"There are still many vacancies in the system," she cautions, "and we must continue to do what we can to attract and retain individuals to work for and stay committed to Alberta Health Services. But the results to date are encouraging."

The biggest gain this year has been seen among licensed practical nurses and health care aides, with an estimated 11 per cent increase in those areas. The number of registered nurses has also risen – by roughly three per cent this year over last.

New strategies have been implemented to bring new nurses into the system, such as recruiters reaching out to nursing students before they graduate, anticipatory hiring strategies, and rapid hire processes that brought more than 250 new nurses into the system over six weeks.

Other efficiencies continue to contribute to the improved picture.

- Most zones have made gains in the overall full-time to part-time ratio.
- A new rotation management project is producing more attractive and more efficient schedules.
- Having health care providers work to full scope of practice increases productivity.
- Nursing costs per worked hour have fallen.
- New models of care are being implemented that encourage teamwork and collaboration.

"A more optimized utilization of current staffing resources is an important factor in addressing some of the clinical workforce pressures," Gordon says.

A workforce summit held in Calgary in September 2011 looked at the changing needs of the Calgary Zone and identified possible ways to meet those needs. The results of that session and a similar session, held in Taber in the South Zone, have been incorporated into the Zone Clinical Workforce Action Plans.

e-People Brings AHS Staff Together, Virtually

"To put over 90,000 people and $6.2 billion in payroll a year on e-People our provincial human resources and payroll system has been one of the largest human resources (HR) transformation projects anywhere in North America," says David Diamond, senior vice president of Human Resources for Alberta Health Services (AHS).

"It's an example of great collaboration with HR, IT and the operations teams working together to make e-People a success."

With Edmonton joining Calgary on e-People in November, there are now more than 60,000 AHS employees on the system. Employees are benefiting from 24 hours a day, seven days a week access to update their personal and direct deposit information along with their benefits online.

e-People also provides the ability to review employment history and apply for positions within AHS. Vital workforce information is available to managers wherever they need it, no matter what time of day.

Royal Alexandra Hospital Weight Wise clinic staff members, from left, Lisa Winkleman, Lise Lambert and Eva Wright show their enthusiasm for the new e-People system.

Previously, AHS inherited 11 legacy payroll systems, adds Diamond. "This was very inefficient; the systems didn't talk to each other." Soon, the remaining 30,000 staff will enjoy e-People. Central Zone will go live in July 2012, with the rest of the province joining in by fiscal year's end.

What does Diamond himself like best about e-People? "I can do a lot of HR administrative work right on my desktop. There's a lot of self-serve, which I really enjoy."

Smart-e-Pants study participant Landon Catt, 35, chats with research team leader Vivian Mushahwar, PhD, an Alberta Innovates-Health Solutions senior scholar at the University of Alberta Faculty of Medicine & Dentistry.

Smart-e-Pants Partnership Relieves Pressure for Spinal Injured

People with reduced mobility, bedridden by illness or wheelchair-dependent are in constant risk of developing pressure ulcers (bedsores) — but a partnership between Alberta Innovates – Health Solutions (AIHS), Alberta Health Services (AHS), the University of Alberta and the University of Calgary is creating the technology for prevention.

"These sores often cause infections, and can lead to life-threatening complications and even death," says Vivian Mushahwar, PhD, an AIHS senior scholar at the University of Alberta Faculty of Medicine & Dentistry.

After studying pressure ulcers in the lab for five years, Mushahwar gathered a team of experts from across Alberta — 16 principal investigators from neuroscience, nano- and micro-technology, biomedical and electrical engineering, as well as rehabilitation medicine — to develop methods for improving function and reducing the secondary complications associated with neural injuries and diseases. With $5 million in funding from AIHS (including support from Alberta Health and

Wellness), the team set its sights on "Sensory Motor Adaptive Rehabilitation Technology" and the AIHS Project SMART team was born.

In just 2 1/2 years, Mushahwar's team has invented Smart-e-Pants, custom undergarments that stimulate the backside muscles of people who have had a spinal cord injury or stroke.

"Smart-e-Pants provide an electrical current for 10 seconds every 10 minutes, stimulating the nerves and muscles to replicate what we do when we 'fidget' in our chair," says Dr. Ming Chan, a rehabilitation medicine specialist for AHS at the Glenrose Rehabilitation Hospital. "Our aim is to prevent pressure ulcers by bringing blood flow and oxygen to the muscles."

After successful pilot testing with 20 participants at the Allen Gray Continuing Care Centre and the Glenrose in early 2011, five more participants joined the pilot at the Foothills Medical Centre in Calgary last autumn.

"I am thrilled to offer this option to patients at Foothills," says Dr. Sean Dukelow, a Project SMART team member, specialist with the Calgary Stroke Program and assistant professor of clinical neurosciences in the Hotchkiss Brain Institute at the University of Calgary. "Not only are pressure ulcers a serious health problem for our patients, the health care costs are considerable. We estimate that pressure ulcers cost the Canadian health care system $3.5 billion a year."

"Vivian's team has been an excellent partner in working with us to tackle this problem," adds Barbara Stoesz, director of adult rehabilitation for Alberta Health Services at the Glenrose.

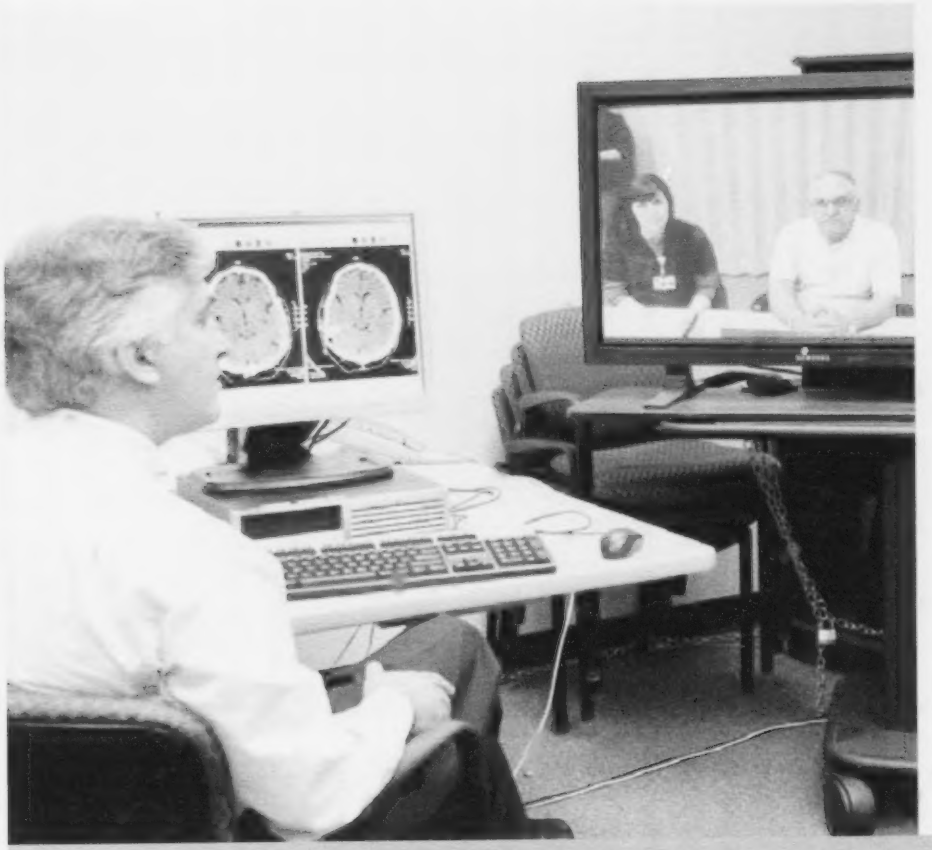
Treating Heart Patients En Route

A new research project in Edmonton has put a heart lab into ambulances. The PROACT (Providing Rapid Out of Hospital Acute Cardiovascular Treatment) project is looking at new ways to treat patients with heart attack and heart failure before they arrive at the emergency department.

"The mobile laboratory will allow us, with a drop of blood, to measure whether heart damage has occurred and whether the likelihood of heart failure is high," says cardiologist Dr. Paul Armstrong. "We're going to see whether bringing the laboratory outside the hospital to the ambulance can expedite the care and lead to a better outcome. We think that's pretty special."

The two-and-a-half year study — which got underway in the fall of 2011 — could lead to a new standard of early intervention and care across Canada and beyond.

From Left: Dr. Robert Welsh, Dr. Justin Ezekowitz, paramedic Emerson North, team member Courtney Bryden and Dr. Paul Armstrong are all part of the PROACT (Providing Rapid Out of Hospital Acute Cardiovascular Treatment) research project which has put a heart-testing lab into Edmonton ambulances.



Telestroke videoconferencing allows specialists in Edmonton or Calgary to quickly see, speak with, analyze and direct treatment to stroke patients, wherever they live in Alberta.

Bridging the Distance to Expert Care

The lives of more than 21,000 Albertans were touched by Telehealth in the past year, up by about 20 per cent from last year.

The videoconferencing technology also bridged the distance in 9,000 cases reviewed by multi-disciplinary teams of clinicians who were managing and supporting patients' clinical pathways.

"An exciting feature of Telehealth is that as the technology keeps improving, the greater the complexity of medical information that can be reviewed by clinicians," says Josephine Amelio, provincial director of Clinical Telehealth.

"It's now possible to share everything from MRIs (magnetic resonance imaging) to ultrasounds."

That level of detail made a difference in the life of a pregnant Edmonton woman, who faced the prospect of travelling to Philadelphia for fetal surgery for spina bifida. Physicians at the Royal Alexandra Hospital and Stollery Children's Hospital were able to connect for the first time to the Children's Hospital of Philadelphia for a fetal medicine consult. After reviewing the case, the medical team determined that the woman wouldn't need to travel to Philadelphia for surgery.

Thanks to Telehealth, there are thousands of other life-enhancing stories:

- In a new program, members of First Nations communities in northern Alberta can now meet via Telehealth to get help monitoring their diabetes and nutrition.

- Through a program called acute Telestroke, Albertans are getting timely, life-saving stroke care that allows specialists in Edmonton or Calgary to quickly see, speak with, analyze and direct treatment to acute stroke patients, at 15 rural sites in Alberta.
- Northern families with infants no longer have to travel to Edmonton to find out if their baby has a hearing loss, thanks to state-of-the-art testing equipment at Northern Lights Regional Health Centre in Fort McMurray and a Telehealth videoconference link to audiologists at the Glenrose Rehabilitation Hospital in Edmonton.
- And through the Western Canadian Children's Heart Network, cardiovascular specialists in Edmonton, Calgary, Vancouver, Winnipeg and Saskatoon meet weekly to review pediatric cases and share expertise.

Michael Long, senior vice president and chief information officer, foresees continued growth for Telehealth. "We expect and promote the increased deployment and use of Telehealth technologies to enhance timely access to specialists, promote collaborative care and improve the patient experience," he says.

Telehealth will continue to extend its reach in the days ahead as it moves into correctional facilities across the province, meaning patients will get specialized and timely care through consults with clinical specialists without leaving the correctional centre.

There's an AHS App for That!

Like a virtual first aid kit, you can take valuable AHS services and tools with you in your pocket or purse.

AHS launched its first mobile iPhone app for the public featuring Calgary-area emergency department wait times and a list of important contact information such as HEALTHLink Alberta, Poison Control and maps for facilities, in fall 2011. An app for Android users followed the launch of the iPhone application.

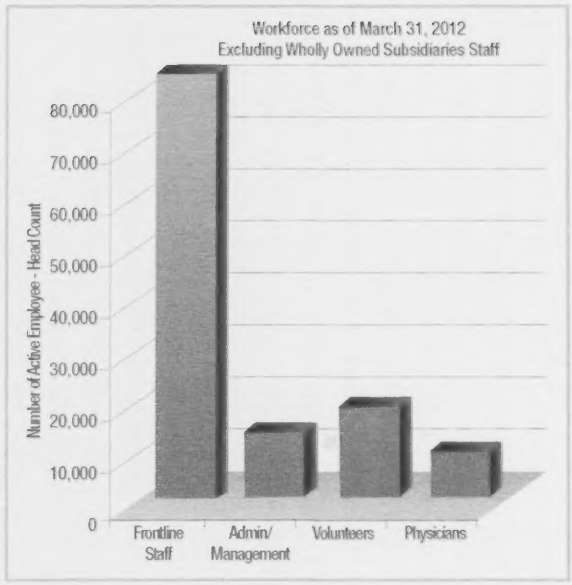
"We are delivering services to patients by providing innovative tools literally at their fingertips," says Dave Brewin, executive director, Access and Information Technology.

The Calgary estimated Emergency Wait Times service contains all the same information as the AHS web page, which was launched in July 2011, plus a map feature. Providing the estimated wait times to the public was also a cutting-edge step for AHS.

"Posting estimated wait times in Calgary was the first step in a provincewide initiative to deliver up-to-the-minute information on what's happening in emergency departments and urgent care centres," says Brewin. More centres will be added to this feature in the months to come.

Who We Are

We are the skilled and dedicated health professionals, support staff, volunteers and physicians who promote wellness and provide health care every day to approximately 3.8 million Albertans, as well as to many residents of southwestern Saskatchewan, southeastern British Columbia and the Northwest Territories. Alberta Health Services (AHS) has almost 100,000 employees, including approximately 91,500 direct AHS employees and approximately 7,900 staff working in AHS wholly-owned subsidiaries such as Carewest, CapitalCare Group and Calgary Laboratory Services (excluding Covenant Health staff), 16,800 volunteers and 8,020 physicians (total physician count for Alberta both employed and independent physicians). Students from Alberta's universities and colleges, as well as from universities and colleges outside of Alberta, receive clinical education in AHS facilities.



Programs and services are offered at over 400 facilities throughout the province, including hospitals, clinics, continuing care facilities, mental health facilities and community health sites. The province also has an extensive network of community-based services designed to assist Albertans maintain and/or improve health status.

Alberta Health Services is required to prepare and submit an annual report to the Minister of Health and Wellness provided to the Minister in the form and manner prescribed and is a key public accountability document that reports how Alberta Health Services discharged its legislated responsibilities and any other responsibilities delegated to it by the Minister. The Minister tables the annual report in the Legislative Assembly.

The roles, responsibilities and accountabilities of Alberta Health Services are further described in the Alberta Health Services Mandate and Roles Document, which was finalized in December 2010.

The legislative responsibilities of Alberta Health Services outlined in Section 5 of the *Regional Health Authorities Act* are to:

- Assess on an ongoing basis the health needs of Albertans:
- Determine priorities in the provision of health services in the Alberta Health Services and allocate resources accordingly:
- Ensure that reasonable access to quality health services is provided in and through the Alberta Health Services:
- Promote and protect the health of the population in Alberta and work towards the prevention of disease and injury:
- Promote the provision of health services in a manner responsive to the needs of individuals and communities and supports the integration of services and facilities in the Alberta Health Services.

All programs and facilities, whether they are owned and operated by AHS or non-profit organizations or private groups, are operated in compliance with specific pieces of program legislation.

Mission, Vision, Values and Strategic Direction

The **Mission** of Alberta Health Services is:

To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

The **Vision** of Alberta Health Services is:

To become the best performing publicly funded health system in Canada.

The **Values** of Alberta Health Services are:

- Respect
- Accountability
- Transparency
- Engagement
- Safety
- Learning
- Performance

Our values have one thing in common: the quality of patient care. Our seven values - respect, accountability, transparency, engagement, safety, learning and performance - drive us, and unite us. Our values describe seven ways we can personally demonstrate our commitment to patient care in our daily interactions with patients, their families and our colleagues. We are all expected to use the values to lead our work, our actions, and our decisions.

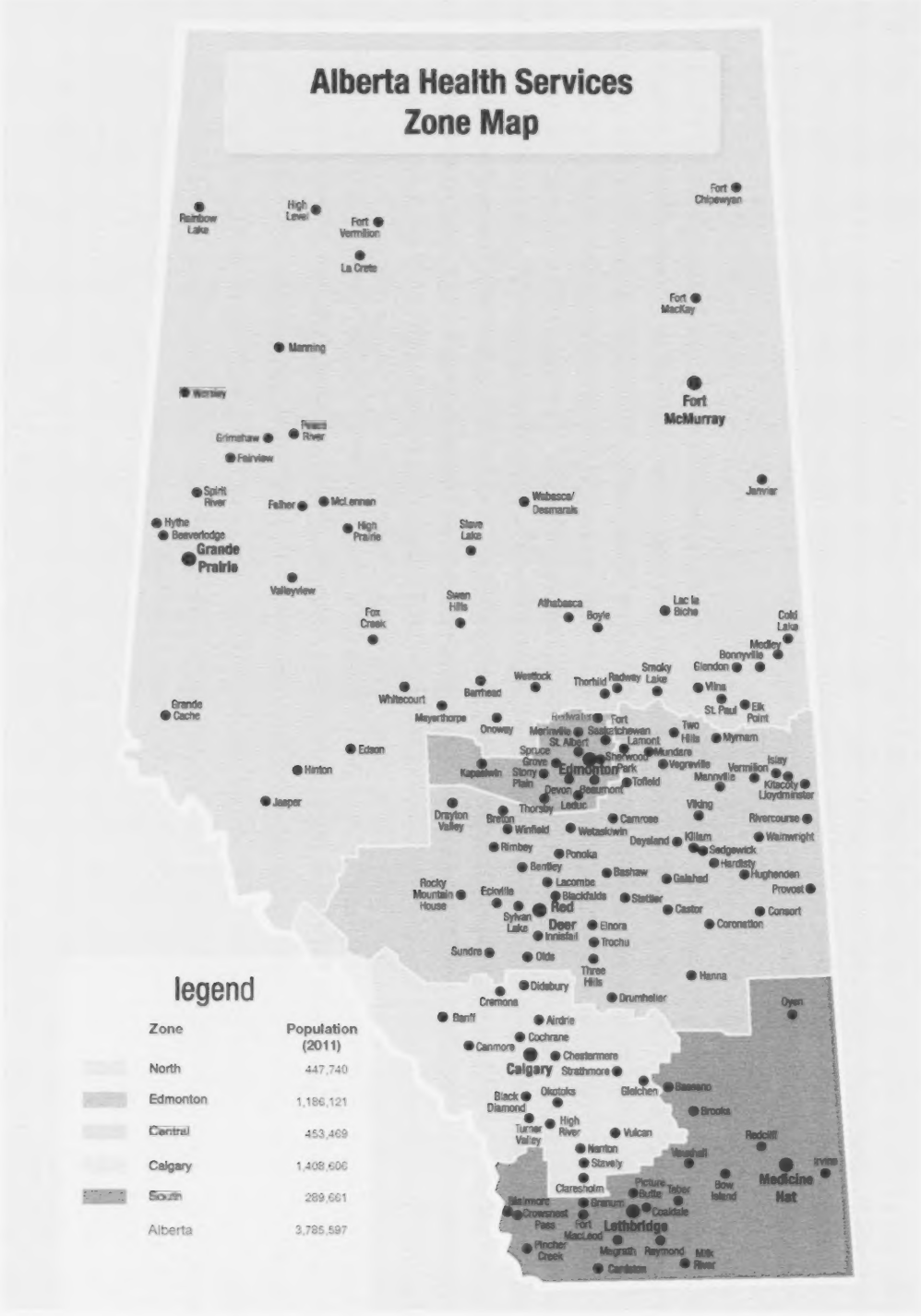
Our **Strategic Direction** is structured around three key **goals**. Our future success will be measured by the health and wellness of Albertans, their ability to access the system and Alberta Health Services' ability to meet these goals within sustainable budgets.

- **Quality:** health care services are safe, effective and patient-focused
- **Access:** appropriate health care services are available
- **Sustainability:** health care services are provided within available resources both now and into the future

This strategic direction has been further shaped by the joint Alberta Health and Wellness and Alberta Health Services document *Alberta's 5-Year Health Action Plan 2010 – 2015*. All activity within Alberta Health Services is aligned with this 5-Year Health Action Plan and is intended to support achievement of mutual targets in a variety of areas.

The Strategic Direction was refreshed and approved by the AHS Board in March 2012. This document builds upon the initial Strategic Direction, and incorporates the new values and other directional shifts that have been identified in the past two years. The Strategic Direction 2012-2015 will be communicated across AHS in late spring 2012.

Map


Alberta Health Services
Zone Map
Rainbow Lake
High Level
Fort Vermilion
La Crete
Fort Chipewyan
Fort MacKay
Manning
Fort McMurray
Grimshaw
Peace River
Fairview
Spirit River
Fairview
McLennan
Wabasca/ Desmarais
Janvier
Hythe
Beaverlodge
Grande Prairie
High Prairie
Slave Lake
Valleyview
Swan Hills
Fox Creek
Athabasca
Boyle
Lac la Biche
Cold Lake
Medley
Bonnyville
Glendon
Smoky Lake
Radway
Thorhild
Westlock
Barrhead
Whitecourt
Mayerthorpe
Onoway
Vilna
St. Paul
Elk Point
Grande Cache
Edson
Hinton
Jasper
Spruce Grove
Stony Plain
Kapasiwin
Edmonton
Sherwood Park
St. Albert
Lamont
Two Hills
Myrnam
Mundare
Vegreville
Vermilion
Islay
Minnville
Kitscoty
Lloydminster
Devon
Beaumont
Tofield
Leduc
Thorsby
Drayton Valley
Breton
Winfield
Wetaskiwin
Camrose
Viking
Rivercourse
Daysland
Killam
Wainwright
Sedgewick
Hardisty
Rimbey
Ponoka
Bentley
Bashaw
Galahad
Hughenden
Provost
Rocky Mountain House
Eckville
Lacombe
Blackfalds
Stettler
Castor
Consort
Sylvan Lake
Red Deer
Elnora
Innisfail
Trochu
Coronation
Sundre
Olds
Three Hills
Hanna
Didsbury
Drumheller
Oyen
Cremona
Banff
Airdrie
Cochrane
Canmore
Chestermere
Calgary
Strathmore
Gleichen
Bassano
Black Diamond
Okotoks
Brooks
Turner Valley
High River
Vulcan
Redcliff
Warner
Stavely
Irvine
Claresholm
Picture Butte
Taber
Bow Island
Medicine Hat
Fort Macleod
Coaldale
Lethbridge
Pincher Creek
Magrath
Raymond
Milk River
Cardston
legend
Zone
Population (2011)
North 447,740
Edmonton 1,186,121
Central 453,469
Calgary 1,409,606
South 289,661
Alberta 3,785,597

Quick Facts

ALBERTA HEALTH SERVICES	2010/2011	2011/2012	% CHANGE
PRIMARY CARE			
Home Care Clients	100,277	104,704	4.4%
Health Link Calls	758,971	766,146	0.9%
EMS Calls/Events	377,280	393,964	4.4%
Number of Vaccinations Administered	1,470,333	1,653,601	12.5%
Public Health Inspections (all programs)	146,293	148,301	1.4%
ACUTE CARE			
Emergency Department Visits (all sites)	1,942,003	2,029,191	4.5%
Urgent Care Visits	177,297	196,137	10.6%
Hospital Discharges	364,041	376,115	3.3%
Births	49,756	50,099	0.7%
Total Hospital Days	2,545,269	2,602,384	2.2%
Average Length of Stay (in days)	7.0	6.9	-1.4%
DIAGNOSTIC/SPECIFIC PROCEDURES			
Total Hip Replacements (scheduled and emergency)	4,467	4,868	9.0%
Total Knee Replacements (scheduled and emergency)	4,990	5,795	16.1%
Cataract Surgery	33,781	36,457	7.9%
Main Operating Room Activity	251,453	265,729	5.7%
MRI Exams[a]	177,422	166,645	-6.1%
CT Exams	333,163	334,614	0.4%
X-rays	1,768,960	1,869,309	5.7%
Lab Tests	66,425,852	70,512,921	6.2%
CANCER CARE			
Cancer Patient Visits	524,420	547,093	4.3%
Cancer Patients Receive Treatment, Care & Support	46,889	48,421	3.3%
ADDICTION & MENTAL HEALTH			
Mental Health Hospital Discharges (acute care sites)	18,647	19,251	3.2%
Community Treatment Orders (CTO) Issued	98	209	113.3%

Notes:
a. MRI exam count converted to new methodology from the Common Procedures Exam List (CPEL) to the Canadian Institute for Health Information (CIHI), this combined with a blitz in Q4 2010-11 of over 10,000 MRI exams, explains the decrease in volumes in 2011-12.

Bed Numbers

NUMBER OF BEDS/SPACES	AS OF MARCH 31, 2011	AS OF MARCH 31, 2012	DIFFERENCE	% CHANGE
Hospital - Acute Care[1]	8,009	8,118	109	1.4%
Subacute in Auxiliary Hospitals[2]	525	525	0	0.0%
Psychiatric - Stand-alone Facilities[3]	850	884	34	4.0%
Addiction Treatment[4]	809	830	21	2.6%
Continuing Care[5]	20,681	21,683	1,002	4.8%
Palliative and Hospice	181	181	0	0.0%
Mental Health Community Beds/Spaces[6]	471	514	43	9.1%
ALBERTA TOTAL	31,526	32,735	1,209	3.8%

Source: AHS Bed Survey as of March 31, 2012

Notes:

[1] Acute Care bed numbers have been revised from 8,071 for March 31, 2011 to 8,009. Acute Care incorrectly reported labour and delivery suites, as well as double-counting beds.

[2] Subacute in Auxiliary Hospital previously reported 408 as of March 31, 2011 and revised to 525 to reflect subacute beds previously reported as long term care beds in auxiliary hospital.

[3] Psychiatric - Stand-alone Facilities previously reported as 884 as of March 31, 2011 and revised to 850, as 34 addiction beds were reported in Claresholm Centre for Mental Health and Addictions.

[4] Addiction Treatment previously reported entire facility bed number (1,343) versus what was funded by AHS (809).

[5] Continuing Care bed numbers have been revised from 20,785 for March 31, 2011 to 20,681 due to previously reported subacute beds under auxiliary hospitals.

[6] Community mental health bed numbers have been revised from 436 for March 31, 2011 to 471, due to site not being reported historically.

Interesting Facts

The Canadian Institute for Health Information (CIHI) released results from the most recent Canadian Hospital Reporting Project (CHRP). The report tracks a series of 21 clinical indicators. In short, Alberta performed among the top three provinces in more than half of the measures (12 of 21) for the most recent years of tracking (2010/11 or 2009/10, depending on the indicator).

Alberta is top-performing province in Canada in the following:

- 30-day in-hospital mortality following stroke
- 28-day readmission after acute myocardial infarction

We ranked second best among the nine provinces in the following areas:

- 30-day in-hospital mortality following acute myocardial infarction
- 30-day readmission (obstetrics)
- Hip fracture surgical procedures performed within 48 hours (wait times across facilities)

AHS ranked third in the following areas:

- 5-day in-hospital mortality following major surgery
- 30-day readmission rate (pediatrics)
- 30-day readmission rate (adult surgical)
- 30-day readmission rate (overall)
- Nursing-sensitive adverse events for surgical patients
- Vaginal birth after caesarean section
- Use of coronary angiography following acute myocardial infarction

Board Governance

Alberta Health Services Board

Tasked with coordinating the delivery of health supports and services across the province, the AHS Board supports the Minister of Health and Wellness' mandate to improve access to care and to create a sustainable health system. The AHS Board reports directly to the Minister.

The following is a list of Board Members who were part of the AHS Board for the fiscal year ended March 31, 2012:

- Ken Hughes (Chair – May 2008 – Dec 2011)
- Catherine Roozen, B.Comm., LLD (Hon) (Vice Chair – July 2008 – Dec 2011; Chair – Dec 2011 – present)
- Don Sieben, B. Comm., DHSA, MBA, FCA (May 2008 – Jan 2012; Vice-Chair – Jan 2012 – present)
- Dr. Ray Block, B.Comm., MAg., PhD, CGA (Feb 2011 – present)
- Teri Lynn Bougie, BA, LLB (Nov 2008 – present)
- Dr. Ruth Collins-Nakai, MD, MBA, FRCPC, MACC, ICD.D (Feb 2011 – present)
- Dr. Kamalesh Gangopadhyay, MD, MRCOG, FRCSC (Oct 2010 – present)
- Don Johnson, BA, B.Sc. (Feb 2011 – present)
- John Lehners, P.Eng., ALS (May 2008 – present)
- Irene Lewis, B.Ed., M.Ed., LLD (Hon) (May 2008 – March 2012)
- Stephen Lockwood, QC (Oct 2010 – to present)
- Dr. Eldon Smith, OC, MD, FRCPC (Feb 2011 – present)
- Sheila Weatherill, OC, BScN., LLD (Hon) (Feb 2011 – present)
- Gord Winkel, P.Eng., M.Sc. (Nov 2008 – present)

Alberta Health Services Board Committees include: Audit and Finance Committee, Quality and Safety Committee, Governance Committee, Health Advisory Committee, Human Resources Committee, and Committee of the Whole.

Alberta Health Services Board Members completed their annual assessment from a governance perspective, which included the effectiveness of Board Committees. This is a standard part of Board assessments and quality improvement.

Accreditation is a requirement for Alberta Health Services. Based on a three-year rotating accreditation schedule, Board and Governance were priorities for the first year which began in 2010 and will be priorities again in 2013.

Advisory Councils

Health Advisory Councils

Each of the twelve Health Advisory Councils established in 2009-2010 consist of ten to fifteen members, including a Chair and each represent a different geographical area:

	HEALTH ADVISORY COUNCIL	GEOGRAPHICAL AREA
1	True North Health Advisory Council	La Crete, High Level & Area
2	Peace Health Advisory Council	Grande Prairie & Area
3	Lesser Slave Lake Health Advisory Council	Slave Lake, High Prairie & Area
4	Wood Buffalo Health Advisory Council	Fort McMurray & Area
5	Lakeland Communities Health Advisory Council	Lac La Biche, Cold Lake & Area
6	Tamarack Health Advisory Council	Hinton, Edson, Slave Lake & Area
7	Greater Edmonton Health Advisory Council	Edmonton & Area
8	Yellowhead East Health Advisory Council	Vegreville, Lloydminster & Area
9	David Thompson Health Advisory Council	Red Deer & Area
10	Prairie Mountain Health Advisory Council	Calgary & Area
11	Palliser Triangle Health Advisory Council	Medicine Hat & Area
12	Oldman River Health Advisory Council	Lethbridge & Area

The mandate of the Health Advisory Councils is to support AHS in achieving its strategies by engaging residents and providing advice and feedback from a local perspective on what is working well in the health care system and on areas in need of improvement in communities across the province. All council members are appointed by the AHS Board.

During the second year of operation, the councils became more established in their communities and hosted a number of community consultations to provide AHS with more feedback from the local perspective regarding health care delivery in communities across the province. As councils become better known in their communities, there are greater opportunities for engagement with community members and organizations. Council members have taken the feedback and comments from these community consultations to inform their dialogue with Alberta Health Services senior leaders.

The second annual Health Advisory Council provincewide meeting was held in Calgary and provided the opportunity for council members to further engage with AHS Board Members and members of the Executive Committee while learning more about engagement and communication techniques to improve their work in communities.

The councils continue to provide feedback on several fronts for Alberta Health Services, which assists in planning processes and strategic development. Several AHS planning initiatives were reviewed by the councils and advice was provided to support this work. Examples include Zone Improvement Plans, the "Just and Trusting Culture" initiative, community and rural health planning, Emergency Medical Services, Medication Reconciliation Project, Concierge Customer Service Initiative, Health Link, organizational realignment, and many aspects of local health care services throughout the province.

Members of the Alberta Health Services Board continue to be informed about council activities and issues which are being addressed with operational leaders, as well as their perspectives on health care. Board members also attend council meetings throughout the province on a regular basis to become more aware of the work of councils and learn directly about local health care services and opportunities for improvement.

Provincial Advisory Councils

Provincial Advisory Council on Cancer

The Provincial Advisory Council on Cancer was established by the Alberta Health Services Board in April 2011, and following recruitment and member appointments, the council held two meetings. The meetings were attended by members of the Alberta Health Services Board and Executive. Several initiatives and projects underway within the Alberta Health Services Cancer Care system were reviewed with the council members to assist them in developing future priority areas for their consideration. Members were consulted on the proposed Alberta Cancer Plan and provided valuable input. Council members initiated development of their work plan for the coming year.

Provincial Advisory Council on Addiction and Mental Health

The provincial Advisory Council on Addiction and Mental Health was established by the Alberta Health Services Board in December 2011. A recruitment process was completed to fill the fifteen council positions. The Alberta Health Services Board will appoint members early in the next fiscal year and it is anticipated that the inaugural meeting of this council will be held prior to the end of June 2012.

Alberta Health Services

2011-2012 Organizational Structure

Dr. Chris Eagle is President and Chief Executive Officer of Alberta Health Services. He leads a staff of almost 100,000 caring and dedicated individuals who make up the AHS workforce, including approximately 91,500 direct AHS employees and approximately 7,900 staff working in AHS wholly owned subsidiaries (excludes Covenant Health staff). In this role, Dr. Eagle is responsible for leading health services through transformational change, shaping the future for AHS to allow achievement of the goals of access, quality and sustainability. He is also responsible to the AHS Board for the organization's day-to-day operations.

AHS has realigned its senior leadership team to create a closer link between strategic planning and operations, and enable more timely decisions at the local level.

Each area is led by a member of the executive team, all reporting directly to the President & Chief Executive Officer.

Our organizational structure is arranged under the following leaders:

- Executive Vice President and Chief Operating Officer
- Executive Vice President and Chief Medical Officer
- Executive Vice President, Strategy and Performance
- Executive Vice President, Chief Development Officer
- Executive Vice President, People and Partners
- Executive Vice President and Chief Financial Officer

As of February 29, 2012

The above structure is currently in the process of being refined and the most recent organizational chart can be found on the AHS website.

Strategic Initiatives, Accomplishments and Results

The 2011-12 fiscal year was a time of progress and improvement for many areas throughout Alberta Health Services. We continued to build on the foundations that were created through operating as one health system, and capitalized on the stability and direction provided by the 5-Year Health Action Plan and the Government of Alberta's five-year health funding commitment.

AHS is committed to becoming a high performing organization which means that, not only should we improve access and quality, but we also need to do so in a manner that is sustainable for the future. Alberta's 5-Year Health Action Plan has established performance goals and a road map of improvements towards building this high performing system. Activity is underway to advance our goals, and we have a number of measures in place to monitor our progress.

The section that follows identifies some of the key initiatives that are underway, along with performance metrics. The results overall indicate widespread organizational improvement, and that many of the efforts that have been initiated during the earlier years of AHS are starting to show positive results. Of the measures we are tracking, the majority of them indicate continual improvement. Some of these improvements are small, while others show quite significant improvement. Examples of this significant improvement are seen in access to some surgeries; access to radiation therapy; and staff, physician, and volunteer engagement. Some areas, however, will require more concerted effort to move the results closer to our goals.

While improvements have been made, many of the established targets—particularly related to access—have not yet been achieved. It should be noted that these targets were deliberately set to be very ambitious and challenging to achieve, to provide a focus for improvement and to mobilize action. We will build on the improvements as we head into 2012-13. Further advancement towards these targets is a high priority for the upcoming year. We anticipate that the results will continue to improve with time, as we build capacity in our communities and focus our efforts across the care continuum, as we work with our partners in primary care, and as the impact of the creation of strategic clinical networks is realized.

Staying Healthy/Improving Population Health

Our foundation to improve the health of all Albertans is to focus on health promotion and reduce health inequities. Enabling people to stay well and to minimize their need to access health services will improve both the quality of life for Albertans and enable the system to be more sustainable. This focus on health promotion and wellness underlies all of what we do across the continuum of care within Alberta Health Services and requires full partnership with the public, government and a variety of stakeholders.

Keeping healthy is essential to achieving a high quality of life. As Alberta's population grows and ages, the number of people with chronic diseases will increase. This will mean more demand for hospital beds, continuing care, and other health services unless we step up our efforts to keep Albertans healthy.

The health system will continue to add and improve the range of services that help people to stay well and avoid injuries and chronic diseases, including the area of addiction and mental health. Prevention and treatment of cancer will also be a key priority. The health system will offer relevant, accurate information to individuals and families, and proven programs and tools to help them achieve their best health. Supporting personal responsibility and self management is critical. We will also work with communities and agencies to create healthier social and physical environments.

Health promotion, disease and injury prevention is addressed in a collaborative manner with Alberta Health and Wellness. Some of the priority areas are:

- Healthy development (birth outcomes, screening and early detection);
- Cancer and chronic disease prevention (healthy weights, tobacco use, screening);
- Injury prevention (suicide, transportation, falls);
- Addiction prevention and mental health promotion (resiliency, stigma and discrimination, alcohol consumption, illicit drug use, gambling);
- Health-promoting social and physical environments (health disparities, built environments, social environments).

PRIORITIES FOR ACTION: POPULATION HEALTH

Improve population health through integrating health promotion, disease and injury prevention programs with other health care delivery services and better co-ordinate, between health and other government and municipal sectors.

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS
Screening Programs Complete the breast cancer screening program application development project; initiate cervical and colorectal cancer screening program database development project. Enhance collaboration with Primary Care Networks, zones, and services along the screening pathways; co-ordinate the various population-based screening program components, including breast, cervical and colorectal. [4.14] Develop and implement social marketing strategy for breast and cervical cancer screening; develop culturally appropriate and translated public educational resources; update education materials and ongoing health care professional education and client correspondence. [4.14]	• Cervical and colorectal cancer screening program database development project has been rolled into a comprehensive screening application project. • AHS-Cervical Screening Program completed a multi-year project with three primary care networks in 2011. Work with these and other primary care networks, as well as other health care providers to enhance supports for cancer screening is ongoing. • In September 2011, the Alberta Cervical Cancer Screening Program was expanded to include nearly 700,000 more women, ensuring higher screening rates and better outcomes for those at risk of developing cancer. The program encourages women to be screened, mails them their pap test results and reminds them of overdue tests. Women ages 21-69, living in Edmonton area, central and northern Alberta, were sent an introductory letter explaining the program. The program is also offered to women in Calgary and southern Alberta. • Rural and remote communities access breast cancer screening through the Screen Test program, in which a mobile mammography trailer visits communities where the service is not regularly available. • The social marketing strategy has been revised and now focuses on bringing women to the website for information to support decision-making around screening. • Colorectal cancer screening resources updated and made available to the public and providers, including translations into six common languages. • The ethno-cultural Community Engagement Project work plan has been developed. Continued work with the North Zone in implementing Cancer Screening Community Action Strategies.
Chronic Disease Prevention Work with AHW to develop and provide public education materials for the prevention of the most common chronic diseases (diabetes, hypertension, heart disease, kidney failure and depression), including where to get help in the community. [4.16]	• In May 2011, phase 1 of "MyHealth.Alberta.ca" was launched. The goal is to create a single place to get health information and useful health tools. The content has been reviewed and updated by AHS health professionals, to make sure that it reflects standards and practices. • In September 2011, AHS launched a provincial Obesity Initiative, a comprehensive five-year plan to address the prevention and management of obesity. The initiative includes services from community-based programs to intensive medical intervention. • Two provincewide chronic disease self-management programs were implemented: Better Choices Better Health, designed to help people living with ongoing health conditions; and *Mind, Exercise, Nutrition, Do it! (MEND)*, promotes healthy weights among children and their families. The programs will be offered in about 60 communities over the next year. • *Grip* magazine and *Grip on Life* website features content written by, and for, youth. The magazine is distributed to junior and senior high schools across Alberta. An evaluation completed in January 2012 indicated that *Grip* reaches the intended audience and has an impact on increasing knowledge and awareness of mental health issues and resources. • The *Bounce Back Book* for ages 5 – 9 has been integrated into a project for Calgary Board of Education noon supervisors through the Alberta Healthy School Community Wellness Fund. The building blocks of resiliency are also used by the CBE on their website. A modification of the Bounce Back Book for the Aboriginal community is currently underway. Focus testing will be done in early 2012. The books are already used in many Aboriginal communities.
Develop a strategy to create environments which are conducive to healthy eating, active living and healthy weights in an effort to reduce cancer and chronic disease. Explore partnerships and funding to begin implementation across Alberta.	• In year one of this strategy, 31 communities participated in 17 planning workshops to launch the *Thr!ve on Wellness* initiative. The *Thr!ve on Wellness* is a joint initiative from AHS and the Alberta Cancer Foundation. The goal is to support communities in promoting active living and healthy eating in an effort to reduce cancer and chronic disease in Alberta. The program aims to reach 100 -150 communities across Alberta. • To support the implementation of the *Thr!ve on Wellness* initiative to over 80+ communities by 2016, the Alberta Cancer Foundation awarded a five year, $10 million grant. • Partnerships with Alberta Health and Wellness, University of Alberta School of Public Health and Public Health Agency of Canada have been established to help guide the overall evaluation of this provincial initiative. • AHS launched the Healthy Eating Environment Policy at the June 2011 meeting of the AHS Board. The policy will increase healthy food and beverage options available in AHS facilities. The goal is to promote health and wellness in AHS facilities to support chronic disease management and prevention.

PRIORITIES FOR ACTION: **POPULATION HEALTH**

Improve population health through integrating health promotion, disease and injury prevention programs with other health care delivery services and better co-ordinate, between health and other government and municipal sectors.

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS
Injury Prevention Identify key areas to align and implement suicide prevention work across AHS. Complete comprehensive evaluation of the Report Impaired Drivers campaign.	• AHS Provincial Steering Committee on Suicide Prevention provides structure for co-ordination and alignment of suicide prevention activities across three portfolios and with other program and service areas of AHS. Key results from an environmental scan informed recommendations for new/adjusted approaches across AHS. The Implementation Strategy was endorsed by the zones and implementation began in November 2011. • The Community Helpers Program provides a model for community capacity building around the issue of youth mental health promotion and aims to promote and maintain individual and community wellness. AHS is operationalizing programming under a restricted grant to carry out integral programming to community helpers. There are 13 project areas across the province that have identified and support community helpers that youth already access when experiencing a mental health problem. • The Alberta Injury Control Strategy Implementation Plan has been developed, facilitated by the Alberta Centre for Injury Control and Research. The implementation plan is a cross-ministry initiative which involves several government ministries, as well as AHS and numerous external stakeholders. • The Calgary Report Impaired Drivers Campaign evaluation was completed and key findings were distributed to provincial partners. The key findings for replication in other settings were highlighted.
Healthy Development Develop strategy to provincially implement A Million Messages – a comprehensive plan to standardize messages given to parents during contact with a community health nurse. Messages are simple, consistent, routine, and target children's issues at the appropriate developmental stage.	• AHS Child Injury Prevention Coordinating Committee established evidence-informed guidelines and population and public health strategies that are developmentally appropriate for child injury prevention practice (birth to 12 year olds) across AHS. • The A Million Messages (AMM) program provides developmentally appropriate, simple, and consistent injury prevention messages to families with children between zero to three years of age in multiple areas of Alberta. The messages are distributed by community health nurses, home visitors, and hospital staff as part of their daily work. Home visitors also have the responsibility to implement environmental modifications, including outlet covers, door knob grips, blind shorteners, plastic ties for wrapping cords, and stair gates. The program is embedded within public health agencies' already-established immunization schedules. The goal is to achieve optimal early childhood development through decreased injuries occurring in the home. • The committee is currently conducting an environmental scan to identify the key messages and resources now used to provide injury prevention information to parents of children birth to six years. The scan will also look at injury prevention staff training and development practices that are used in the zones. Once the AMM within AHS project is completed in December 2012, the Committee will focus on developing strategies to prevent injuries among school-age children.
Screening • Newborn metabolic screening: provincial standards and guidelines developed and implemented. Evaluation plan developed. [4.3]	• The Newborn Metabolic Screening (NMS) Action Plan was implemented in January 2011 and standardizes screening practices for newborns. To date, five key projects have been completed: Alert Distribution, Lab Capacity, Frameworks: Communication, Knowledge Exchange, and Evaluation. A parent information sheet was developed and distributed in September 2011. Work continues on 13 other key projects to standardize NMS Program within AHS. Blood samples are tested for 17 metabolic disorders, in 2010-11, 183 positive screening results were reported with 99.41 per cent infants screened out of 50,561 infants born in Alberta in 2010-11. The main reason for an infant not being screened is neonatal death. • An examination of the process and the outcomes associated with the implementation of Newborn Metabolic Screening action plan is underway.
• Preschool developmental screening: five projects and evaluations complete, final provincial evaluation complete, economic analysis complete, plan for next steps developed with cross-ministry committee.	• AHS is co-chairing a cross-ministry committee to develop a comprehensive approach to infant and preschool screening and follow-up services. This work is being informed by the Preschool Developmental Screening Demonstration Projects and other work. Final reports were received by Alberta Health and Wellness. • AHS is operationalizing the action items outlined in the Children's Mental Health Plan through restricted grant funding provided by Alberta Health and Wellness.
• Safe infant sleep: environmental scan, evidence-based key messages established, strategy developed to support professionals communicating key messages, process and outcome evaluation plans developed.	• Evidence-based parent and professional resources were created and disseminated in collaboration with internal and external stakeholders. A web-based professional education module and webinars are complete and available to all AHS staff. • An evaluation of the process and the resource is in progress. A safe infant sleep parent survey was conducted between April and September 2011. The goal of the parent survey is to conduct a baseline assessment of parents' awareness of safe sleep messages, their attitudes, their current practices related to infant sleep practices among professionals and parents. • A safe infant sleep policy is currently under development. The policy will outline the importance and safety associated with having infants sleep on their backs and the risks associated with bed sharing.
• Healthy births: jointly with AHW, increase support to healthy births including those targeted at FASD. [4.2]	• Collaborative work with Alberta Health and Wellness and other key stakeholders to develop an Alberta Perinatal Health Strategy has begun.

PRIORITIES FOR ACTION: POPULATION HEALTH

Improve population health through integrating health promotion, disease and injury prevention programs with other health care delivery services and better co-ordinate, between health and other government and municipal sectors.

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS
• Healthy Alberta: work with AHW to promote healthy eating and active living through communities and schools (Comprehensive School Health (CSH) program). [4.1]	• New partnerships have been formed with several school jurisdictions who have not been previously engaged in work with the Healthy Weights Initiative Health Promotion Coordinators. • Representatives from AHS's Comprehensive School Health program, Healthy Weights Initiative, and event partners Ever Active Schools, shared ideas and success stories with more than 300 participants at the Ever Active Healthy Active Schools Symposium. These symposiums promote healthier environments and behaviors.
Addiction and Mental Health Finalize development of provincial tobacco cessation framework for AHS. Tobacco cessation health professional training standardized. Coaching/Knowledge Exchange Community of Practice in place for zone addiction prevention staff. Complete evaluation of mental health promotion resources for children, youth and parents and determine future options.	• The tobacco cessation framework for AHS was completed. • The health professional training program (The Building Capacity of Health Care Providers to Offer Tobacco Cessation Interventions) enhances cessation services in Alberta by building capacity in front-line health professional staff (physicians, nurses, respiratory therapists, mental health therapists, occupational therapists, etc.) to offer tobacco cessation interventions in health care facilities. • AHS is operationalizing the Mental Health Capacity Building and has 38 projects in 47 communities and 119 schools, throughout Alberta. The diversity of approaches and programming are reflective of the needs and resources of individual communities, including engagement of traditionally under-served populations. • Tobacco Reduction and Cessation program materials have been developed and distributed throughout the five health zones. Across the province, 2,075 health professionals have been trained. This project was sponsored through a contribution agreement with Health Canada through March 31, 2012. • The Building Capacity of Health Care Providers to Offer Tobacco Cessation Interventions project has been moved to core funding which will allow for the continuation of Tobacco Reduction and Cessation training. Online training components are in development with a go-live date scheduled for September 2012. • The AHS Addiction Prevention Unit co-ordinated and facilitated two Coaching and Knowledge Exchange (CAKE) events in 2011. A diverse audience of over 50 AHS Addiction and Mental Health field staff and community prevention partners from 35 sites attended each of these CAKE events. CAKE provides an opportunity to share ideas, learn about new approaches and to connect as practitioners' and stakeholders in addiction prevention. • *Grip* magazine and *Grip on Life* website features content written by and for youth. The magazine is distributed to junior and senior high schools across Alberta. An evaluation completed in January 2012 indicated that *Grip* reaches the intended audience and has an impact on increasing knowledge and awareness of mental health issues and resources. • The *Bounce Back Book* for ages five to nine has been integrated into a project for Calgary Board of Education (CBE) Noon Supervisors through the Alberta Healthy School Community Wellness Fund. The building blocks of resiliency are also used by the CBE on their website. A modification of the Bounce Back Book for the Aboriginal community is currently underway. Focus testing will be done in early 2012. The books are already used in many Aboriginal communities.
Environmental Public Health Investigate and plan for a new information system provincewide for Environmental Public Health.	• Approval for a project to explore feasibility of implementing recommendations from the Food Safety review as well as a provincewide information system. The project will launch at the end of April 2012 for both business operations and information technology planning.
Develop strategies to improve restaurant inspection rate.	• Food facility inspection rate maintained at 88% of permitted facilities provincewide. There were 87,549 Safe Food Program Inspections in 2011-12 an increase of 436 inspections since 2010-11.
Aboriginal Health/ Reducing Disparities Create partnerships with Aboriginal communities to begin to address health issues and concerns. Develop and present cross-cultural education forums. Develop a strategic plan to assist Aboriginal people to improve their health. Develop an AHS framework and strategy for reducing health disparities.	• Three Agreements-in-Principle signed. Cross-ministry (Alberta Health and Wellness, Intergovernmental, International and Aboriginal Relations, First Nations and Inuit Health Branch, AHS) meetings held on key operational issues to improve alignment, access and implementation of health programs for Aboriginal Peoples. • Aboriginal Health Specialist, a lead role in Cultural Competency, was created. • Promoting Health Equity Framework was completed; Action planning in process. • AHS held an Aboriginal Peoples and Communities Workshop in early 2012. The workshop topics included: Aboriginal Culture and Practices in Contemporary, Counseling for Addictions Aboriginal Philosophies and their Practices, Impact of Historical Events of Aboriginal Community, and Journey of Tobacco – What is Protocol? sessions. • Aboriginal Health Action Plan completed with consultation. Wisdom Council Planning Committee implemented. Draft document created that outlines the alignment between AHW and AHS plans and strategies in aboriginal health.

PRIORITIES FOR ACTION: **POPULATION HEALTH**

Improve population health through integrating health promotion, disease and injury prevention programs with other health care delivery services and better co-ordinate, between health and other government and municipal sectors.

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS
Communicable disease control Develop and implement a comprehensive sexually transmitted infections (STI) control plan including: • An education and awareness campaign targeted to those at risk of getting an STI. [4.18] • Increased availability of prevention coordinators to educate those at risk of getting an STI. [4.19]	• 12 prevention coordinators were hired specifically to reach out to high-risk populations in an effort to increase knowledge about sexually transmitted illnesses and to change unsafe behaviors. • Evaluation shows STI awareness increased as a result of the coordinators' outreach efforts. • Coordinators have presented 50 educational sessions and attended 10 health fairs (to increase awareness of sexually transmitted infection prevention) across the province. • Prenatal congenital syphilis coordinators (one in Calgary and one in Edmonton) have identified agencies and organizations to partner with to facilitate access to hard-to-reach pregnant women in the community. • No women were identified with infectious syphilis at the time of delivery in 2011 compared to 2010 when there were three cases and six cases were identified in 2009. The target of zero was achieved.

In Summary: In conjunction with AHW, numerous initiatives have been developed, implemented and strengthened in the areas of screening programs, chronic disease prevention, injury prevention, healthy development, addiction and mental health, environmental public health and aboriginal health/reducing disparities and communicable disease control. In addition to improving quality of life, these initiatives will help to increase life expectancy and reduce potential years of life lost.

The following results demonstrate slow, but generally steady improvement in life expectancy. More significant improvements have been shown in the reduction in potential years of life lost. Overall, provincial life expectancy compares favorable to the Canadian average.

While many of these initiatives take time to show their full impact, through continued focus in this area, it is anticipated that disparities in life expectancy throughout various AHS zones in the province will decrease, and that there will be an increase in life expectancy among First Nations populations.

Screening is also important in helping with early detection of cancer. The following chart indicates significant improvement in colorectal screening, however additional effort will be required in the future to improve screening in all cancers.

PERFORMANCE MEASURE	2005	2006	2007	2008	2009	2010	2011	2011/2012 TARGETS
Life Expectancy: (Provincial) The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics. Both sexes combined.	80.1	80.4	80.6	80.6	81.1	81.6	81.9	Over the next five years, Alberta Health and Wellness expects that life expectancy would increase in a manner consistent with the Canadian average, with the goal being to be above the national average of 80.9 years (2006/2008 per Statistics Canada).
South Zone	79.0	79.5	80.2	79.6	80.1	80.3	81.1	There is an expectation that the disparities in life expectancy throughout various zones in the province would decrease over the next five years, with the goal of having life expectancy in all geographical zones above the Canadian average.
Calgary Zone	81.6	81.7	81.7	81.9	82.4	82.9	83.4	
Central Zone	78.6	79.4	79.3	79.5	80.1	80.7	80.5	
Edmonton Zone	80.3	80.5	80.8	80.8	81.0	81.8	81.9	
North Zone	77.8	78.1	78.6	78.3	79.3	79.8	79.4	
First Nations	70.4	70.0	70.6	69.4	70.8	71.9	70.5	There is an expectation that there will be an increase in life expectancy among First Nations populations over the next five years.
Non-First Nations	80.5	80.8	81.0	81.0	81.5	82.0	82.3	
Potential Years of Life Lost per 1,000 Population: The total number of years not lived by an individual who died before their 75th birthday.								
Total Population	53.1	50.8	50.5	50.3	47.3	44.8	43.3	There is an expectation that Potential Years of Life Lost will be monitored, and that improvements will be seen in PYLL over the next five years.
Females	38.9	38.0	38.4	37.7	37.1	33.9	33.2	
Males	67.2	63.5	62.6	62.8	57.4	55.5	53.2	

Sources: Alberta Health and Wellness

PERFORMANCE MEASURE	2008	2009	2011	2015 TARGETS
Colorectal Cancer Screening Participation Rate	36.0%	43.0%	57.0%	55%
PERFORMANCE MEASURE	2008/2009	2009/2010	2010/2011	2010-2015 TARGETS
Breast Cancer Screening Participation Rate	55.9%	57.3%	54.8%	55% - 62%
PERFORMANCE MEASURE	2007 - 2009	2008 - 2010	2009 - 2011	2010-2015 TARGETS
Cervical Cancer Screening Participation Rate	70.7%	67.9%	65.0%	70% - 75%

Sources: Canadian Community Health Survey (2008) and Colon Cancer Screening in Canada Survey by Canadian Partnership Against Cancer.
Alberta Breast Cancer Screening Program and Alberta Health and Wellness.
Extracted from AHW Fee for Service data.

Building a Primary Care Foundation

Patient-centred, co-ordinated and comprehensive health care provided through a robust primary care system has been shown to improve the health of the population, and to increase the efficiency of health care delivery.

With an aging population and chronic disease on the rise, it is imperative that we offer Albertans access to the best primary care system, and in turn, the best opportunity to maintain good health and access to the services they need, when they need them.

Another key issue that needs to be addressed is supporting individuals with addiction and mental health issues. Improving both prevention and access to supports and services in this area are critical.

PRIORITIES FOR ACTION: **PREVENTION**

Improving Immunization Rates

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS
In conjunction with zone operations, develop a seasonal Influenza plan that addresses the need to increase immunization coverage rate for influenza. [4.22]	• In the 2011-12 influenza season, AHS Communicable Disease Control distributed vaccine to additional community providers throughout the province, including pharmacists and physicians. • In Calgary and Edmonton, for example, the vaccine was distributed to 15% more community providers than the previous season. Provincial data quantifying the total doses of vaccine administered by community providers is now being collected. • Overall, number of vaccination doses delivered to Albertans increased by approximately 12.5% - this increase includes number of doses delivered by partners (physicians, pharmacists etc). Seasonal influenza dosages increased 5%. • A mass immunization and rapid response plan was completed in May 2011 and presented to the pandemic sub-committee in June 2011. Work still underway on vaccine inventory and prioritization of populations.
Develop a mass immunization and rapid response plan to be included in pandemic plans.	• A mass immunization and rapid response plan was completed in May 2011 and presented to the pandemic sub-committee in June 2011. Work still underway on vaccine inventory and prioritization of populations.
In conjunction with zone operations, develop plans to address childhood immunization rates. This will include review of evidence-based strategies to address immunization and consultations to identify 1) barriers to immunization 2) barriers to access immunization clinics 3) need for parent education/consultation and 4) immunization data collection across the province. [4.21]	• AHS has implemented several strategies to eliminate potential barriers that could prevent parents or caregivers from immunizing their children. Reminder phone calls and mail outs are designed to reduce the number of no-shows at scheduled appointments. • In some communities with high no-show rates, extra clinics – including some drop-in clinics – have been established to make immunization more convenient for parents and caregivers. • Collaborated with community partners such as child care centres to identify under immunized children and worked through barriers to provide immunization. • A survey was developed to determine what front-line staff feel are the barriers to immunization. The survey is expected to be completed by the end of April 2012. The results will be summarized, and a provincial plan will then be completed for end of May 2012.

In Summary: In 2011-12, there were 1,653,601 total vaccinations administered which is an 12.5% increase from 2009 (the last normal year not confounded by H1N1 data of 2010). As noted below, rates of seasonal influenza demonstrated continual improvement from previous years, increasing doses delivered by 5 per cent.

There are pockets of low immunization across the province, which impacts the overall achievement of the provincial target. Specific strategies will be developed to increase the immunization rate closer to the target by identifying why some children are not immunized, and to increase access and modify existing immunization delivery programs to best suit the local population.

PERFORMANCE MEASURE	2008/2009	2009/2010	2010/2011	2011/2012	2011/2012 TARGETS
Rates of seasonal influenza immunization by age group (as of April 30th – end of season):					
Adults aged 65 and older	58%	56%	59%	61%	75%
Children aged 6 to 23 months	43%	16%	27%	30%	75%

PERFORMANCE MEASURE	2006	2007	2008	2009	2010	2011/2012 TARGETS
Rates of childhood immunization by two (2) years of age:						
Diphtheria/ Tetanus/ acellular Pertussis, Polio, Hib	80.0%	83.7%	83.8%	Data not available at time of report for 2009 to current		97%
Measles/Mumps/Rubella	91.0%	88.5%	89.3%			98%

Sources: Alberta Health and Wellness and Alberta Health Services

Above Seniors (adults aged 65 and older) Influenza Immunization Rate based upon the influenza season and therefore considers doses delivered from October through to May 15th. The rate up to March 31st as reported by Alberta Health and Wellness (AHW) was 55.5%.

Above Children (aged 6 to 23 months) Influenza Immunization Rate based upon the influenza season and therefore considers doses delivered from October through to May 15th. The rate up to March 31st as reported by Alberta Health and Wellness is 28.5%.

PRIORITIES FOR ACTION: PRIMARY HEALTH CARE

Apply and advance a patient-focused model of primary health care that offers care in the community, and provides a team-based provider approach.

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS
Complete a primary health care strategy and primary care model. Strategic priorities addressed will include funding models, access to specialty care, infrastructure, inter-professional teams, involvement of nurses and other health care providers, information technology/ information management (IT/ IM), quality improvement indicators and governance. [3.2, 3.18, 3.19]	• Work continues to be undertaken to develop a primary health care strategy and primary care model. In the latter part of the year, planning was undertaken to initiate three pilot Family Care Clinics (FCCs) in Calgary, Edmonton and Slave Lake. Significant work will be undertaken in this area in the upcoming year. • Internal consultation with zones and population health is underway to support the evolution of the primary care model and support the transition from a primary care system to a primary health care system. External consultation with AHW on the development of a primary health care model that aligns with FCC's is underway. • The Knowledge Generating and Management Advisory Committee provides a common venue for dialogue surrounding performance measures, indicator development and the interface to evaluation, research and other areas of quality improvement. New members will be added from the universities of Alberta and Calgary (Family Medicine areas). Further development of a research agenda will be required as university partners enter into this committee. • AHS continues to be involved in provincial committees related to health human resources in primary care. • Work on other providers on the primary health care team is being incorporated into work on FCC care teams to ensure standardization of team member roles.
Expand access to primary health care teams. (Work with AHW to increase access to Primary Care Networks (PCN). [3.1]	• A proposed set of core services developed and shared with AHS governance members for inclusion in business plan renewals where appropriate. Meeting with PCN physician leads held in late October and core services material revised based on stakeholder input. • An inventory of best practices and primary care initiatives that target unattached individuals and families has been created and a Primary Care Model, which incorporates strategies to link unattached patients to primary care teams, has been developed and submitted for approval. • An outline analysis of the options relating to the provision of AHS HR Support Services to PCNs has been conducted. • As of March 31, 2012, 40 Primary Care Networks (PCNs) are operating and a Letter of Intent (LOI) for a PCN in Drayton Valley has been approved. Following previous approvals of the LOIs for PCNs in Olds, Sundre and Grand Cache, work on business plans are progressing. The LOI for a PCN in Jasper is being reviewed for approval. • Nearly 2.9 million Albertans are attached to Primary Care Network providers. • The three pilot Family Care Clinics sites (FCCs) were chosen in order to provide better access to populations identified as having higher needs for primary health care as well issues with access.

PRIORITIES FOR ACTION: **PRIMARY HEALTH CARE**

Apply and advance a patient-focused model of primary health care that offers care in the community, and provides a team-based provider approach.

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS

Develop quality improvement strategies (e.g., Access Improvement Measures - AIM) to reduce wait times to see a primary care provider. [3.4]	• Alberta AIM is a "made in Alberta" quality improvement initiative which supports physicians and teams both in primary, specialty care as well as AHS regional programs. AIM adds unique value to the health system in Alberta because of the principled approach to improvement and the way it is applied with the lens of improving access and reducing delays for patients. The focus of the initiative is access improvement by decreasing wait times for appointments and process efficiency by decreasing waits at appointments. Simply, improved access leads to improved clinical care.
	• Preliminary results for AIM 10-13 (Calgary, Canmore and Medicine Hat clinics) relating to access (as measured by Time to Third Next Available Appointment - TNA) highlight that teams proceeding through AIM continue to make substantial progress in improving access following their participation in AIM:
	  • 63% of all clinics made an improvement in the Time to Third Next Available Appointment (TNA)
	  • 56% of all primary care clinics made an improvement in TNA
	  • 67% of specialty care clinics made an improvement in TNA
	• Other AIM initiatives impacting wait times for key provincial initiatives include:
	  • Wait-times for musculoskeletal (MSK) surgeries: Edmonton and Calgary MSK clinics are currently participating.
	  • Wait-times for cataract surgery: Royal Alexandra Hospital Ophthalmology Clinic; will impact surgical capacity
	  • Hospital admissions and emergency visits prevented by primary care provision or managed at a family physicians office: Numerous primary care providers have participated in AIM over the last 20 collaboratives with emerging evidence that improved access within primary care has a demonstrable impact on hospital admissions and emergency visits.
	  • Children's mental health access within 30 days: 17 addiction and mental health teams have participated in AIM in the last 18 months, specifically 4 of these are denoted as Children's Mental Health teams.
	  • Immunization: Public Health (Immunization) from the North Zone will participate in AIM in Grande Prairie.
	• Alberta AIM is managed out of the Primary Care Innovation and Integration portfolio within Alberta Health Services but is funded from a specific grant from Alberta Health and Wellness. Program governance is provided through a multi-stakeholder Steering Committee, comprised of representatives from Alberta Health and Wellness, Primary Care Initiative, the Alberta Medical Association, Toward Optimized Practice, family physicians, and Alberta Health Services.

In Summary: Continued improvement is noted in the chart below with increases in the per cent of Albertans attached to a primary care network.

In the latter part of the year, significant work was undertaken to develop the first of three pilot Family Care Clinics to expand access to primary health care. Over the next year AHS will work closely with AHW to expand this model.

PERFORMANCE MEASURE	APR 2008	APR 2009	APR 2010	APR 2011	APR 2012	2011/2012 TARGETS
Percentage of Albertans attached to a primary health care provider in a primary care network.	50%	59%	64%	72%	75%	Not Determined

Sources: Alberta Health and Wellness; April 2012

PRIORITIES FOR ACTION: **PRIMARY CARE**

Reduce the number of hospital visits and admissions that could have potentially been prevented through the provision of appropriate non-hospital health services.

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS
Develop a provincial pathway for improving diabetes care in Alberta in alignment with the Chronic Disease Management Strategy. This includes quality improvement to reduce diabetes hospital admissions. Develop a provincial pathway for improving care for Albertans who are overweight or obese.	• A pathway is under development for severe recurrent hypoglycemia. • Provincial process maps that cross the continuum of care have been developed. Clinical processes for adult specialty care under development in each zone by the provincial Bariatric Resource team. The zone process maps will be specifically structured around zone volumes, provider capacity and integration of services with primary care and chronic disease management. • Core service components within the pediatric care pathway are being developed along with the identification of supporting tools and resources; exploration and validation of the required tools and resources continues with public health, primary and specialty care.
Implement Chronic Disease Management (CDM) Strategy including: • Develop CDM supports for diverse and vulnerable populations • Develop effective screening for CDM in primary care • Develop a provincial integrated community based CDM program model • Develop, standardize and evaluate approaches to self-management • Establish a framework that allows integration of chronic disease registries to identify populations and improve management of disease • Develop system wide case management model in collaboration with Seniors Health • Develop a provincial education strategy for inter-professional care in CDM • Share information and best practice to prevent and manage chronic disease. [3.15]	• A provincial framework for diverse and vulnerable populations, a cultural safety approach, and a draft evaluation framework was completed. Patient education tools were modified. • Integrated community based chronic disease management charter drafted and distributed for review with executive decision to not fund project, thus suspending work on the charter. Hiring currently underway in the zones to prepare for service expansion via 2011-2012 funding. Zone consultation process completed to develop priorities for CDM clinical standards and guidelines development. • A self-management workbook to assist with complex care planning was developed and a distribution plan was implemented. One program, Better Choices, Better Health™, implemented across all zones using agreed upon model and standards. Evaluation framework elements being prioritized to align with community-based integrated CDM Program. • Interactive Continuity of Care Record Enabling CDM Care AHW grant received to develop a pilot project to implement a Primary Care Chronic Disease Support system using the CIHI Primary Health Care Electronic Medical Record Content Standard within the new Family Care Clinics • Updates pertaining to system wide case management are detailed in the Q4 Performance Reporting from Senior's Health. • CDM provider education strategy and implementation plan was developed and priorities established for program development. Request for Proposal process completed to support Vascular Risk Reduction online module development.
Implement an Alberta referral directory.	• AHS has developed a standardized 'closed-loop' referral approach that ensures patient information is fully and freely shared between general practitioners and specialists across the province, ensuring patients receive high-quality, stream-lined care as well as timely follow-up with their family doctor or primary health care team. Work is underway to determine the implementation plan of this approach. • Meanwhile, two 'rapid access' clinics, operating in tandem in Calgary and Edmonton, are now providing a single point of entry for lung cancer patients across the province, as part of the Expedited Management of Lung Cancer Program. Specially trained nurses and nurse practitioners, with physician support, will assess and triage patients and then navigate them through the many diagnostic tests needed before a treatment decision can be made. About 4,000 patients a year are expected to be referred to the clinics by 2013. The program aims to ensure that, by March 2013, 75 per cent of patients will wait no longer than 30 days from the time of referral from their primary care physician to when a treatment decision is made, and 60 days from the time of referral from their primary care physician to surgery.
Implement Personal Health Portal. [3.12]	• A health knowledge base from a leading developer of consumer health content (Healthwise) has been selected and implemented to provide evidence-based clinical content and online tools. A multi-stakeholder steering committee, working group and integrated clinical working group provided guidance on the features and functionality offered by the Personal Health Portal and appropriate governance models.

PRIORITIES FOR ACTION: **PRIMARY CARE**

Reduce the number of hospital visits and admissions that could have potentially been prevented through the provision of appropriate non-hospital health services.

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS
Work with AHW to consult with health care professionals to develop policies for a primary navigation model for use in Alberta's health care system. [1.26]	• A joint AHW/AHS Policy Health System Patient Navigation Committee was established to overview work for the Health System Navigation Project which is inclusive of acute care, primary care, mental health and cancer care. Consultation occurred in June 2011 and a final report was received in September 2011. • Final copies of AHW commissioned Patient Navigation Conceptual Model, Business Case and Policy Framework received September 2011. • Initial three year proposal developed and submitted to AHW November 2011. Videoconference held December 2011 to receive feedback on proposal and to more closely align work with "closed-loop" referral proposal and access initiative. • Draft three year grant funding proposal submitted to AHW January 2012.
Develop urgent care and community health centre models and standards: • Develop urgent care decision support framework • Develop urgent care staffing mix model and service delivery standards • Complete community ambulatory care centre review and recommendations • Develop provincial framework and standards for community health centres	• Decision support tool was completed and is ready to be tested on community data. • This "tool" is a framework that will be applied to community assessments to support the decision for appropriate service planning for Community Ambulatory Care Centres (CACC) including Advanced Ambulatory Care Centres and Urgent Care Centres. It will use indicators to support the identification of the CACC service needs based on population need, capacity and capability. It will support the right service, in the right place, at the right time for the right population. • Urgent Care benchmarking completed which informed staffing model for nursing and unit clerks.

In Summary: As noted below, performance remains better than the target for Ambulatory Care Sensitive Conditions and Family Practice Sensitive Conditions continue to show improvement since last year.

AHS and Primary Care Networks (PCNs), Urgent Care Centres and Family Care Clinics will continue to work on decreasing hospital admissions and emergency visits by focusing on chronic disease management and prevention, maximizing the use of inter-professional teams (e.g. social workers and mental health providers), and also ensuring that hospital flow and transitions with the community are appropriate.

PERFORMANCE MEASURE	2008/2009	2009/2010	2010/2011	2011/2012	2011/2012 TARGETS
Ambulatory Care Sensitive Conditions: Rate of hospital admissions for health conditions that may be prevented or managed by appropriate primary health care.	298.0	283.5	278.9	278.1	297
Family Practice Sensitive Conditions: Percent of emergency department or urgent care visits for health conditions that may be appropriately managed at a family physician's office.	28%	27.4%	27.5%	26.4%	25%

Sources: AHS Discharge Abstract Database and Provincial Ambulatory (ED/Urgent Care) Abstract Data

PRIORITIES FOR ACTION: **MENTAL HEALTH AND ADDICTIONS**

Improve the availability and accessibility of mental health and addiction services for Albertans in community settings, especially services for children and youth.

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS
In collaboration with AHW, develop one provincial strategy and a comprehensive action plan for addiction and mental health services with a focus on: [3.9] • Suicide prevention	• The Provincial Suicide Prevention Required Organizational Practices Working Group was initiated to support meeting accreditation standards for suicide prevention across Addiction and Mental Health (Dec 2011). • The new Suicide Risk Management policy suite came into effect in November 2011 and reflects the key priorities of quality improvement and patient safety for Alberta Health Services (AHS) Addiction and Mental Health. The goal of this harmonization of standards for suicide risk assessment and management is to improve the safety of patients receiving care on AHS Acute Psychiatric Inpatient Units who are at risk for suicide.
• Treatment of depression	• Clinical pathways have been developed for Adult Depression which will focus on the primary care environment and support the provision of short term psychosocial interventions. This has been piloted in the Calgary Zone. • An Adolescent Depression clinical pathways was developed and piloted with an initial focus on outpatient mental health clinics with linkages to primary care and additional referral sources.
• Standardized screening and assessment for mental health disorders	• "A Standard Approach to Screening" resource paper describes a standard approach to screening for concurrent disorders in Addiction and Mental Health (A&MH) services, a menu of evidence based tools and considerations for implementing this approach at a system and service level.
• Improved services for children and youth at risk • Continue to implement the Children's Mental Health Plan for Alberta. All 23 actions will be underway with evaluation mechanisms in place.	• The Children's Mental Health Plan for Alberta is a three-year action plan that supports a co-ordinated and collaborative approach to optimizing the mental health and well-being of infants, children and youth up to 24 years of age, and their families. It builds on successful strategies (i.e., Mental Health Innovation Fund projects, and Mental Health Capacity Building projects) and promotes new initiatives that enhance collaborative approaches between health services, schools and communities all across the province (rural and urban), while addressing the diverse and complex needs of Aboriginal and immigrant/refugee children and youth. • The Mental Health Capacity Building component of the Children's Mental Health Plan has been fully implemented and staffed. Full implementation of initiatives is ongoing in some of the zones.

• Adopt a concurrent capable approach for addiction and mental health services through development and implementation of standardized screening and assessment; includes training staff in organizations serving young adults to screen, assess and intervene in cases related to addiction (Edmonton, Red Deer, Calgary) [3.8]	• To support staff and programs in adopting a concurrent capable approach to care across A&MH services the following practice resources and tools have been developed to support Enhancing Concurrent Capability (ECC):
	  • ECC: What Does it Mean to be Concurrent Capable?
	  • ECC: Foundational Concepts Paper- These resources describe some of the key concepts and components of a concurrent capable approach to addiction and mental health service delivery.
	  • ECC: A Toolkit for Manager and Staff - This "toolkit" for managers and clinicians will be developed over time to support implementation of the eight essential components of concurrent capable care. ECC Toolkit Chapter One: A Welcoming and Engaging Strategy - The first chapter provides tools and ideas to aid A&MH staff in welcoming and engaging A&MH clients into service and promotes the philosophy that "any door is the right door" for entry.
	  • ECC: Summary of Provincial Forum - This first ever provincial forum (February 23-24, 2012) brought together A&MH champions from all zones to share practice improvements and lessons learned in enhancing concurrent disorder capable services across the province. This summary provides an overview of the presentations, discussions and evaluations of the event.

• More access to mental health services in correctional and remand centres • Increase the access and quality of addiction and mental health services (assessment, treatment and transition) provided within Alberta correctional and remand centres.	• Community Transition Teams were implemented in Peace River, Edmonton, Red Deer, Calgary, and Medicine Hat. Staff training in October confirmed program protocols and increased community linkages. • Enhanced training provided to health care staff (both Safe Com and non-Safe com) on a number of enhanced addiction and mental health assessment tools. Enhanced addiction and mental health screening and assessment fully implemented in all South correctional facilities and started in the north in December 2011. • The Men's Addiction Treatment Program at Fort Saskatchewan Correctional Centre was launched in August 2011. Results of initial evaluations showed that participants benefit from attending the full program. • The Women's Mental Health Program at Fort Saskatchewan Correctional Centre has been renamed A Woman's Path. The program increases access to trauma-related substance use treatment. A Woman's Path includes personal development modules, process groups and multidisciplinary case conferencing. Initial programming started in December 2011. • Recruitment completed for 34 of 42 Safe Communities funded addiction and mental health staff to the provincial facilities. • Recruitment completed for 22 of 25 Safe Communities transition team members working within the zone operations but linking closely with correctional facilities. • Six addiction and mental health educational sessions have been completed for Correctional Peace Officers. A total of 841 staff has received this highly interactive education. Future training for new officers will be delivered in conjunction with the Alberta Solicitor General Staff College as part of the core new officer training. • Ongoing training and support for Addiction and Mental Health staff on the use of the following tools: HONOS, the additional screening questions for addictions and mental health and the enhanced mental health assessment. Over 130 AHS staff from the correctional centres have participated in this training.

PRIORITIES FOR ACTION: MENTAL HEALTH AND ADDICTIONS

Improve the availability and accessibility of mental health and addiction services for Albertans in community settings, especially services for children and youth.

ACTIONS (in collaboration with AHW)	PROGRESS/RESULTS
• Professional development for staff • Develop a framework for clinical development and support with identified core competencies and required professional development/training systems.	• Initiated the development of A&MH Professional Development Strategy, established a working group, and identified/ defined core competencies. Listed menu of professional development opportunities under Addiction and Mental Health internal web page.
Work to further develop services including: • Add new hospital and transition beds for mental health patients [3.5]	• An additional 44 geriatric mental health beds were made available last year in Edmonton with the opening of Villa Caritas, a 150-bed facility that serves seniors with complex mental health and medical needs. The additional beds represent a six per cent increase in the number of local geriatric mental beds (712). All 106 patients from the Geriatric Mental Health Program, formerly based at Alberta Hospital Edmonton, moved into the modern, three-storey, $51.4 million building. • In October 2011, the St. Therese-St. Paul Healthcare Centre re-opened in its 10-bed psychiatric unit, which was closed in 2009 due to staffing challenges. The re-opened psychiatric unit can now detain formal or involuntary patients; previously the unit could only serve patients who sought mental health care.
• Add new mental health community spaces throughout Alberta and new mental health staff to schools and clinics [3.6, 3.7]	• AHS added 30 community addiction and mental health beds in 2011-12 including: 24 community addiction and mental health beds in Edmonton at Anderson Hall (Step-down from acute Mental Health care) and Allendale House (Forensic Group Home); and six community mental health beds in Calgary at Lighthouse (Forensic Group Home). • The evaluation of the Young Adult Treatment Program has been ongoing, with the standard utilization and pre-post results being collected. Remaining evaluation includes analysis of the service provider interviews and a client-follow up study. New target completion date is for late fall 2012. • The Mental Health Capacity Building component of the Children's Mental Health Plan has been fully implemented and staffed. For the plan, over 75 staff have been hired. Full implementation of initiatives is ongoing in some of the zones. Recruitment to positions continues. The newly hired mental health professionals have implemented community mental health promotion, prevention and early intervention programs in nearly 120 schools in about 50 communities across the province.
• Implement the *In Roads* program to improve access to screening, assessment, referral, early intervention and treatment services for youth and young adults (12 to 24 years) who are at risk for, or have developed, a substance use problem.	• The *In Roads* project has been fully implemented in the communities of Calgary, Red Deer and Edmonton. Staff from nearly 27 communities received training in how best to support young adults with substance-abuse issues and how to encourage these individuals to make positive lifestyle changes. Community agency staff who participate in the project were given screening, assessment, brief intervention and referral tools and techniques that will improve their ability to make a positive difference in the lives of these young adults. • 100 per cent of community agency respondents agree, or strongly agree, that the *In Roads* program strengthened the relationship between their agency and AHS. Over 85 per cent of service providers report incorporating the skills and knowledge learned into their practice. 93 per cent of service providers indicate that as a result of the *In Roads* program, they are confident in their ability to match clients.
• Evaluate key actions from 2009-2010, including Community Treatment Orders (CTOs) and Safe Communities initiatives.	• Changes were made to the criteria for certification of patients under the Act, notification provisions to family physicians were added, and Community Treatment Orders (CTOs) were introduced. Additionally, the Alberta Mental Health Patient Advocate's powers of investigation were extended to persons under one certificate and individuals subject to a CTO. As well, the jurisdiction of Review Panels was extended to include persons subject to a CTO. • The AHS external website houses the Mental Health Act electronic forms, resources such as flow charts and the Guide to the Alberta Mental Health Act and Community Treatment Order Legislation as well as links to other sites and materials. • This CTO Resources page will be utilized to house materials designed for "internal AHS use only" and will evolve as new resources are developed. • Six Safe Observation and Assessment beds were opened at the Royal Alexandra Hospital in December 2011 under the Safe Communities Initiative. • The Mental Health Amendment Act/CTOs Evaluation Steering Committee co-chaired by AHS and AHW has developed and approved an evaluation plan and framework and is undertaking evaluation activities.
• Develop a provincial sourcing strategy for addiction and mental health contracted services.	• Completed a three-year contract procurement schedule for Addiction Mental and Health. • Selected vendors for the Request for Proposal (RFP) for Non Medical Detox services contract. • Consulted with zone operational leads and Contract Procurement and Supply Management (CPSM) on the effectiveness of the procurement process. • CPSM has developed a new sourcing strategy.

In Summary: In September 2011, a comprehensive Alberta's Addiction and Mental Health Strategy was released. Over the past year, significant work has been implemented to improve addiction and mental health delivery systems for all age groups. Although there are many ways to measure and monitor the progress in improving mental health services, currently the emphasis has been on children's mental health. We will work with AHW to develop other measures.

The chart below indicates slight improvement from last year in access to children's mental health services, however we are not yet achieving target. This is attributable to challenges in specific areas in the province as well as data collection issues. Efforts have been focused at zones which remain below target for the performance measure related to children's mental health services access and will continue in the upcoming year.

Access to Children's Mental Health Services:

PERFORMANCE MEASURE	2008/2009	2010/2011	2011/2012	2011/2012 TARGETS
Percentage of children aged 0 to 17 years receiving scheduled mental health treatment within 30 days.	Not Available Prior to AHS	75%	76%	90%

Sources: AHS Mental Health Services

Improving Access, Reducing Wait Times

Alberta is taking action to reduce wait times throughout the health system. The province will do this by increasing capacity in the system, matching capacity to demand at the right time and looking at new and innovative ways of delivering appropriate care by the best provider.

Timely access to services supports good clinical outcomes as it reduces the risk of complications due to further deterioration of health, unnecessary investigations and admissions, and the burden on families and other supports.

The development of provincial standards for clinical practice and access will assist in stabilizing and improving access, quality, and the sustainability of care.

PRIORITIES FOR ACTION: ACCESS TO SURGERY

Reduce the wait time for surgical procedures

ACTIONS	PROGRESS/RESULTS
• Ramp up surgical activity. [1.13]	• There were approximately 265,729 "net new" surgeries completed in 2011-12, up from 251,453 – a 6 per cent increase, including: • 36,457 cataract surgeries performed in 2011–12, up from 33,781 the previous year – an 8 per cent increase. • 3,556 hip replacement surgeries performed in 2011–12, up from 3,153 the previous year – a 13 per cent increase. • 5,184 knee replacements performed in 2011–12, up from 4,397 the previous year – an 18 per cent increase.
• Perform additional endoscopies. [1.14]	• Approximately 3,555 additional screening colonoscopies were completed by March 2012. • Work is underway on the Alberta Colorectal Cancer Screening Program (ACRCSP) to increase the number of screening colonoscopies performed in 2011-12. This program is an organized provincial colorectal cancer screening program co-ordinated by AHS in partnership with health care providers. ACRCSP is dedicated to increasing the number.
• Improve quality through better access to surgery supported by innovations including: • Develop a standardized approach to assess, refer and book patients with specialists (cancer, cardiac, hip/knee, and cataract). [1.20]	• AHS has developed a standardized referral approach that ensures patient information is fully and freely shared between general practitioners and specialists across the province, ensuring patients receive high-quality, stream-lined care as well as timely follow-up with their family doctor or primary health care team. Work is underway to determine the implementation plan of this approach. Meanwhile, two 'rapid access' clinics, operating in tandem in Calgary and Edmonton, are now providing a single point of entry for lung cancer patients across the province, as part of the Expedited Management of Lung Cancer Program. Specially trained nurses and nurse practitioners, with physician support, will assess and triage patients and then navigate them through the many diagnostic tests needed before a treatment decision can be made. About 4,000 patients a year are expected to be referred to the clinics by 2013. The program aims to ensure that, by March 2013, 75 per cent of patients will wait no longer than 30 days from the time of referral from their primary care physician to when a treatment decision is made, and 60 days from the time of referral from their primary care physician to surgery.
• Develop integrated care and treatment plans for at least three major diseases, including mental illness, heart conditions and bone and joint health. [1.23] • Develop common surgical pathways.	More than three clinical pathways developed including: • Arthritis: The Arthritis Working Group is a multidisciplinary team created provincial integrated care pathways for osteoarthritis and rheumatoid arthritis. The pathway goal is to improve effectiveness and efficiency across the continuum of care for arthritis patients, and to increase public awareness, education and satisfaction within the arthritis continuum of care. • Hip and Knee Arthroplasty: The Hip and Knee Working Group is a multidisciplinary team from 12 arthroplasty sites across Alberta. By implementing a standardized clinical pathway, each site has developed individualized plans to meet targets based on best practice that will reduce length of stay, reduce surgery wait times, and improve the patient experience and patient safety. It is projected that the provincewide implementation of this clinical pathway will have the potential to free up 16,000 hospital days, ultimately creating improved access throughout the province. • Hip Fracture – Acute Care: The Bone and Joint Clinical Network oversees the Hip Fracture Clinical Pathway, developed by multidisciplinary clinicians across the province, to ensure a clinical pathway for hip fractures is operationalized provincewide. The pathway is evidence based, with the goal to have patients receive surgery within 48 hours of injury and have patients mobilized one day after surgery. • Depression: The Addiction and Mental Health Clinical Network developed a depression pathway for use by primary care physicians that ensures patients presenting with depression are provided with a plan of care supported by evidence-based practice. The goal to collaboratively spread this pathway to the rest of Alberta, with frontline clinicians adapting it to their local services and resources.
• Surgical network – establish common operating room information systems and common definitions; improve processes from referral to surgical discharge, leading to standardized utilization provincially. • Develop patient condition/diagnosis descriptions and recommended wait time targets for each surgical specialty group.	• The aCATS project (Adult Coding Access Targets for Surgery) is developing standard access targets by diagnosis. These targets will be used to define timeframes in which surgeries should be booked. As of March 31, 2012, pilot is ready to launch at nine sites for seven surgical sub-specialties. Technical readiness achieved. Remaining sub-specialties incorporated in the pilot fall 2012. Pilot complete with evaluation and sustainability plan by September 2013.

PRIORITIES FOR ACTION: ACCESS TO SURGERY

Reduce the wait time for surgical procedures

ACTIONS	PROGRESS/RESULTS
• Implement bone and joint central intake model and practice standards.	Engaging expert clinicians who provide bone and joint health care for patients and families across Alberta, the Bone and Joint Clinical Network aims to: • Improve access to services for patients and families, based on best practice and evidence. • Reduce variability in care processes so patients and families have a positive and predictable care experience. • Improve efficiencies in the system by eliminating waste.
• Roll out cardiac surgery central intake model. • Improve utilization of pre-op assessment clinics. • Create new and innovative contracting methodologies for non-hospital surgical facilities (NHSF).	The Surgery Clinical Network will address the following priorities in alignment with AHS strategic goals: • Develop standardized wait-time definitions across AHS sites and identify access targets for high-volume, high-impact surgical services (cancer surgery as a first priority). These will be based on best available evidence or expert clinical consensus where evidence does not exist. The Surgery Clinical Network has: • Approved draft definitions for surgery wait times in collaboration with the work completed by the Bone and Joint Clinical Network. • Completed a snapshot inventory of all operating rooms in AHS and Covenant Health hospitals. • Completed a preliminary analysis of available surgery activity data. • Developed prioritization principles for access to cancer surgery. • Approved a model for health technology assessment and innovation for surgery, including a recommended approach to evaluating innovative technologies and approaches to surgical care.

In Summary: As demonstrated below, improvements have been made in many of the surgical wait time measures as well as volumes of surgeries have increased significantly. There were approximately 265,729 surgeries completed in 2011-12, up from 251,453 – a 6 per cent increase.

The most dramatic improvement was seen in cataract surgery where wait times are 35.1 weeks in 2011-12, down from 46.9 weeks last year, a 25 per cent improvement. A number of initiatives have been introduced to reduce wait times for hip, knee, cataracts and other surgeries which has demonstrated improvement in Q4, and we anticipate continued improvement in the upcoming year as wait lists are reduced.

Provincewide Access to Surgery: wait time as defined by the maximum time that nine out of ten people will wait (in weeks) from decision to treat to treatment.

WAIT TIMES FOR SURGERY	2009/2010	2010/2011	2011/2012	2011/2012 TARGETS
CABG Urgency I - Urgent	2.4 weeks	2.1 weeks	1.9 weeks	1.0 week
CABG Urgency II – Semi Urgent	7.0 weeks	6.4 weeks	6.2 weeks	2.0 weeks
CABG Urgency III - Scheduled	31.0 weeks	24.0 weeks	28.8 weeks	6.0 weeks
Wait Time for Hip Replacement Surgery	36.4 weeks	39.4 weeks	39.8 weeks	27.0 weeks
Wait Time for Knee Replacement Surgery	49.1 weeks	49.1 weeks	48.0 weeks	35.0 weeks
Wait Time for Cataract Surgery	41.0 weeks	46.9 weeks	35.1 weeks	30.0 weeks
Wait Time for all other Scheduled Surgery	24.6 weeks	25.7 weeks	25.9 weeks	TBD

CABG = Coronary Artery Bypass Graft.

Sources: AHS Open Heart Wait List Database (Edmonton), VELOS, APPROACH and OR data from ORIS, the OR database (Calgary); DIMR from Site Surgery Wait List and Surgical Databases; and Alberta Health and Wellness

PRIORITIES FOR ACTION: **CANCER CARE**

Increase access in the treatment of Cancer

ACTIONS	PROGRESS/RESULTS
• Work with AHW to develop a provincial strategy for cancer care that considers immediate and future needs for establishing infrastructure, workforce and activities required for continuous improvement in access, quality and sustainability in Cancer Care. [1.18]	• AHS worked with AHW to develop a provincial strategy for cancer care. The plan was vetted by multiple stakeholders to ensure input and awareness of the plan. This long term plan will establish priorities for cancer care and other AHS departments and establish a baseline for budget discussions with AHS, AHW and the Alberta Cancer Foundation. • Approval by the Health Minister of the Alberta Cancer Plan and dissemination to AHS and the public will occur in late spring 2012.
Open new radiation sites in Lethbridge and Red Deer. [1.16]	• Clinical implementation of Prostate Intensity Modulated Radiation Therapy program was completed. • The first phase of the Lethbridge redevelopment was completed and patient treatment was started in June 2010. Further work will expand capacity from one to two linear accelerators. In Red Deer, construction started in September 2010, with a target opening date for radiation treatment in Q1, 2013.
Improve productivity in radiation therapy delivery. • Improved throughput and reduced wait times were achieved in 2010 provincially. Further work using LEAN processes will address the wait times from patient referral to specialist consultation.	• The LEAN project has been initiated to address the increased wait time. The project is being completed at three centers within Alberta, the Cross Cancer Institute in Edmonton, the Tom Baker Centre in Calgary and the Jack Ady Center in Lethbridge. This project has been divided into three phases, with phase one and two running concurrently. • Phase 1 is a process review of the new patient offices will be completed to reduce the "turnaround" time that is required to receive, process, and triage patient referrals. This will include the new patient office as well as the processes within the First Patient Contact initiative that is currently underway in all of the cancer centers in Alberta. Progress has been made. Complete reorganization of the new patient office has occurred and there are further plans to move this group into a new better suite location in May 2012. This move will allow for greater efficiency of workflow for the staff involved in the process. Also increased amounts of work have been dedicated to the quality improvement of information that is located within the Electronic scheduling system (ARIA) to ensure that accurate reporting is received by managers to make appropriate decision on decreasing wait times. The First Patient Contact initiative is meeting targets and will be expanded to all tumor groups by 4th quarter 2012-13. Currently wait times have decreased to less than 27 days for 87 per cent of our patients. • Phase 2 will be a review of the current scheduling of patents within the Outpatient Department (OPD). This will include the scheduling of rooms and manpower to support the activities required by the patients. Discussions with all staff involved in the OPD will be required to ensure that they have input into the changes and are supportive of these potential changes. There is a current review of data with utilization of current clinics and the flow of patients through the department.
Establish a cancer patient navigation system that will support coordination of care, access to services and provision of information. [1.25]	• The "First Contact" program was established so new patients can be contacted within 48 hours and given appointment dates. The program is operating at the Tom Baker Cancer Centre in Calgary for four tumor groups: genitourinary, breast, gastro-intestinal and hematology; and at the Cross Cancer Institute in Edmonton for 2 tumor groups: lung and breast. • Phased implementation of the First Contact program was initiated in September 2010 at the Tom Baker Cancer Centre (TBCC) and in November 2010 at the Cross Cancer Institute (CCI). The first phase will be limited to two tumor programs at each of the CCI and TBCC. Implementation will continue for all cancer care sites and for all tumor groups by the end of 2012–13.

In Summary: Improvements have been made to reduce wait times for radiation therapy both in "referral to first consult" and in "ready to treat to first radiation treatment". There has been significant improvement in the past two years, with "ready to treat to first radiation treatment" continuing to be better than target.

While improvements have been made reducing wait times for referral to first consult, targets have not yet been achieved. The last two quarters of the year show a positive trend (Q3 was 4.9 weeks and Q4 was 4.6 weeks) and continued efforts are underway to further reduce these wait times for the upcoming year.

There were 5,193 consultations for radiation therapy in 2011-12, up from 4,784 over last year, a 9 per cent increase in volume. The anticipated 2013 opening of the Central Alberta Cancer Centre in Red Deer may reduce wait times further.

Access to Cancer Treatment – Radiation Therapy (The maximum time that nine out of ten people will wait (in weeks)

PERFORMANCE MEASURE	2009/2010	2010/2011	2011/2012	2011/2012 TARGETS
Wait time for radiation therapy - *referral to first consult*: From referral to the time of their first appointment with a radiation oncologist, by facility:	7.4 weeks	6.0 weeks	5.3 weeks	4 weeks
Wait time for radiation therapy - *Ready to Treat to First Radiation Treatment*: From the time of a medical prescription for radiation therapy to the start of radiation therapy, by facility:	5.4 weeks	3.6 weeks	3.1 weeks	4 weeks

Sources: Cancer Care

PRIORITIES FOR ACTION: EMERGENCY DEPARTMENT SERVICES

Reduce the length of stay for patients in emergency departments. Improve access to Health Link services (i.e., telephone advice and health information).

ACTIONS	PROGRESS/RESULTS
Add 12 new treatment spaces to emergency department at Stollery Children's Hospital. [1.2]	• Edmonton's first emergency department dedicated to pediatric and family-centred care opened in January 2012. • A $26.3-million renovation at Stollery Children's Hospital expanded and separated the Stollery's emergency department from the University of Alberta Hospital. • Phase 1 opened in January 2012 with a dedicated pediatric walk-in entrance, triage stations, patient registration and a waiting room with child play area. A new family consultation room, enhanced work space for the pediatric emergency physicians and a trauma room will open later in 2012. • About 1,240 square metres (13,350 square feet) of newly constructed space have been added to the existing ED. • Since opening, the Stollery ED experienced a 15 per cent increase in patient visits in February compared to same time last year. Despite this increase, 77 per cent of patients were discharged within four hours.
Implement emergency department re-direction projects for seniors. Appropriately redirect seniors home from emergency departments, with appropriate supports (e.g., home care). [1.9].	• The Emergency Department to Home (ED2Home) program was implemented in Calgary, Edmonton, Red Deer and St. Albert throughout 2010. During the 2010 pilot project, 17 per cent of seniors who visited an emergency department (ED) in Edmonton, Calgary and Red Deer were connected with community home care programs to better manage their health needs. • The program was expanded to Medicine Hat, Ponoka, Wetaskiwin in 2011; Fort McMurray, Grande Prairie in 2012. • ED care co-ordinators connect ED patients, ages 65 and older, with other appropriate, community health care services, including home care, which can help them make necessary adjustments in their routines, medications and/or living environment. The goal is to keep seniors safe and healthy in their communities and to help them avoid preventable hospital visits. • In March of 2012, a knowledge translation day was held in Leduc to report findings from the evaluation of the four initial sites. Key stakeholders including frontline staff, management, physicians and representatives from Alberta Health and Wellness attended.
Redirect EMS clients to urgent care centres.	• EMS currently transports patients to five Urgent Care Centres (UCC) in metropolitan areas. EMS transports will start going to Advanced Ambulatory Care Centers. New mandatory Transport Destination Algorithm and guidelines were developed and implemented in January 2012 and resulting in increased transports to UCC.
Expand role of emergency medical technicians and paramedics, and implement assessment, treatment and referral protocols to prevent unnecessary emergency department admissions and promote referral to the appropriate health and/or social service. [1.8]	• Develop "Assess, Treat and Refer" protocols: EMS has the ability to respond to calls where the paramedic assesses and can treat the patient on-scene and not transport to hospital; for example, a call from an individual with diabetes whose sugar levels are too low, or patients who are experiencing accelerated heart rate requiring medication to control it. Paramedics have been able to treat the patient to recover from the incident and release the patient without transporting. The patient is referred to follow up with their family physician. • Since January 2012, two new similar clinical protocols are being piloted in Edmonton Metro – one for fainting events in adult patients younger than 40 years of age and another for seizure events in patients with a history of seizures. Both protocols have detailed criteria that must be met for the patient to qualify to be left at home, as not all patients will meet these criteria and may still need to be transported to the hospital. Paramedics will treat these patients on-scene and, if hospital transport is not required, they will leave the patient in the care of a family member who can ensure there is no change in the patient's condition after EMS leaves. They are asked to call 9-1-1 if the patient's condition changes. These patients are also referred to follow-up with their family physician. Patients who have not been transported to hospital under these protocols will be contacted within two days of the event to evaluate the effect of not being transported to the hospital. • The CHAPS Program (Community Health and Pre-Hospital Support) utilizes EMS practitioners to identify individuals living in the community who may need home care or other services to lower their risk of falls and/or deteriorating health. An assessment tool is used to assist in identifying at-risk individuals. Pilot projects in Calgary, Edmonton and Parkland County showed the program reduced the number of repeat EMS calls and emergency department visits by individuals referred by EMS to Home Care. The provincial roll-out has been completed. The CHAPS Program is part of the larger "Emergency to Home" (ED2Home) project.

PRIORITIES FOR ACTION: **EMERGENCY DEPARTMENT SERVICES**

Reduce the length of stay for patients in emergency departments. Improve access to Health Link services (i.e., telephone advice and health information).

ACTIONS	PROGRESS/RESULTS
Implement system flow initiatives in hospitals, including processes for timely and efficient discharge. [1.4]	• The implementation of the Acute Care Capacity Management Program is in progress. • Medworxx computer software was implemented at several sites provincially including the University of Alberta Hospital, Royal Alexandra Hospital, and Alberta Hospital Edmonton to help with patient discharge communication and to identify patients who are ready for discharge. The software was implemented in roughly 2000 beds in Edmonton Zone. • Real Time ED Dashboard implemented in Edmonton Zone in April 2011. • Real Time public view of ED wait times implemented in Calgary Zone in July 2011.
Care Transformation Project - Implement the development of an integrated plan of care within 90 minutes of admission, and enable redesign of care delivery for patients admitted to general internal medicine units at the University of Alberta Hospital.	• Workforce Model Transformation proof of concept initiative was approved and implemented in medicine patient care units at University of Alberta Hospital (UAH), Royal Alexandra Hospital and Medicine Hat Regional Hospital. The initial project at UAH demonstrated positive outcomes pertaining to the team based care, integrated plans of care, increased number of patients returning home (and not to continuing care), shorter length of stay, and increased throughput of patients through the targeted service areas.
Enhance the role of Health Link Alberta, primary care services, urgent care centres and other innovative alternatives to improve 24/7 access to appropriate services, in the appropriate time and place. [1.3]	• A five-year Health Link Alberta Strategic Plan has been developed. Various stakeholder consultations were held with Health Advisory Councils, zones, Alberta Health and Wellness, and Health Link Alberta staff.

In Summary: Numerous initiatives were implemented over the past year to reduce length of stay in the Emergency Department. The chart below demonstrates improvements from previous years at the same time the volume of activity seen in the Emergency Department grew 4.5 per cent from 1,942,003 to 2,029,191; and Urgent Care visits increased 11 per cent from 177,297 to 196,137.

While achievement of targets did not occur, it is well recognized that the length of stay in Emergency Departments is dependent on the functioning of the entire system. In addition it should be noted that the volume of activity in the busiest 16 sites increased by almost 9 per cent. We will continue to focus on this area addressing the recommendations from the HQCA report on Emergency Care.

Also, supporting the delivery of right care at the right time, are the services provided by Health Link. The volume of Health Link calls increased by 1 per cent from 758,971 to 766,146 and the response time also improved in the past year (a 76 per cent improvement in response time since 2008-09).

EMERGENCY DEPARTMENT LENGTH OF STAY	2009/2010	2010/2011	2011/2012	2011/2012 TARGETS
Percentage of patients treated and discharged from the Emergency Department within 4 hours:				
Busiest 16 Sites	63%	64%	65%	75%
All Sites	80%	78%	80%	84%
Percentage of patients treated and admitted to hospital from the Emergency Department within 8 hours:				
Busiest 15 Sites	38%	41%	45%	60%
All Sites	49%	53%	55%	65%

Sources: Calgary and Edmonton Emergency Department Information System Data and AHS Ambulatory Care Reporting System Data

PERFORMANCE MEASURE	2008/2009	2009/2010	2010/2011	2011/2012	2011/2012 TARGETS
Health Link Wait Time: Percentage of calls to Health Link Alberta that are answered within two minutes.	46%	66%	78%	81%	80% in 2 minutes

Sources: Health Link Alberta, Nortel Contact Centre Management 6.0

PRIORITIES FOR ACTION: PATIENT SAFETY

Improve patient safety across the care continuum.

ACTIONS	PROGRESS/RESULTS

Increase standardization and appropriateness for practice by developing clinical pathways through the Clinical Networks.	• The following clinical pathways were developed or in progress for completion in 2012-13:
	  • Hip Fracture-Acute Care
	  • Osteoarthritis and Inflammatory Arthritis
	  • Hip and Knee Arthroplasty
	  • Adult Depression
	  • Adolescent Depression
	  • Sleep Disorders
	  • Pediatric Asthma Clinical Pathways
	  • Alberta Thoracic Oncology Program (formerly Early Diagnosis of Lung Cancer)

Complete full deployment of the Reporting and Learning System (RLS) application (Datix) across AHS.	• The Reporting and Learning System (RLS) was fully deployed across Alberta Health Services. A system upgrade to version 10.6 successfully implemented. The system maintenance tracking process is currently being developed. • The new AHS Reporting and Learning System for Patient Safety has replaced 12 separate systems previously running in the province, making it the provincial system to enable consistent reporting, evaluation and learning from hazards, close calls and adverse events. • The RLS builds on the culture of safety already in place and encourages further participation in the reporting of events we can learn from. It is one component of Alberta Health Services' provincewide patient safety approach to enhance the quality of care and safety for patients and staff.
Develop and implement a plan for promoting "Just Culture."	• Work is underway including consultations and information sessions held with multiple AHS partners. A draft policy and principles has been developed.

PRIORITIES FOR ACTION: PATIENT SAFETY

Improve patient safety across the care continuum.

ACTIONS	PROGRESS/RESULTS
In alignment with the Patient Safety Framework established jointly with Alberta Health and Wellness, develop and implement a quality/safety education and training curriculum to help build internal capability for quality/safety improvement. [5.7]	• Five quality and safety courses are currently implemented and ongoing across the province. • Fundamentals of Patient Safety (FPS) was offered approximately ten times per month throughout the province with 1041 individuals participating in 2011, and 391 to March 31, 2012. FPS telehealth pilot was completed across three sites (Hinton, Grand Prairie, Westlock). • Disclosure of Unanticipated Medical Outcomes (DUMO) courses was fully implemented with 448 participants in 2011, and another 549 to March 31, 2012 (this included physicians trained). 21 individuals have completed the DUMO Facilitation course (seven of whom are certified). • AIW Leadership Webinars are ongoing, with five completed in 2011-12 with a total of 486 participants. The Webinar on "Managing Change to Achieve Results" was held in March with 94 participants.
Work with AHW to ensure a health response is in place for public emergencies including pandemic, acts of terrorism and natural disasters. [5.12]	• Re-assessments of existing AHS critical infrastructure sites completed. Three additional acute care sites assessed jointly with Solicitor General's Office and Site Administrations. AHS E/DM and Protection Services attended the Alberta Security and Strategic Intelligence Support Team (ASSIST) invitational forum in October 2011. AHS Protective Services (PS) Central Dispatch identified as AHS single point of contact for ASSIST. Protocols developed with PS for management and distribution of alerts within AHS. • AHS Emergency Medical Services (EMS) and Emergency / Disaster Management (E/DM) participated in the development of the health section of the Provincial Mass Gathering Guide. The Alberta Emergency Management Agency is in the process of prepping the guide for publication. Once the guide is published, AHS E/DM will advise key internal AHS stakeholders of its availability and will post a link to the guide on the E/DM web page. • The ICS 100 e-learning module to become part of My Learning (April 2012). • Zone Emergency Operations Center Plans are being standardized across the zones. Incident Command Post Plans are to be developed. Education and training of targeted staff to be done.
Achieve provincial integration of surveillance initiatives for MRSA, *C-difficile* associated disease, and central venous catheter blood stream infections in intensive care units as part of provincewide system for tracking and controlling outbreaks of contagious disease. [5.11]	• Developed, approved and implemented Antimicrobial Resistant Organism Surveillance Protocol • MRSA Blood Stream Infections: commenced with Q3 2011-12 Performance Measure report. • Developed a central venous catheter blood stream infections surveillance protocol and performance measure report.
Collaborate with AHW to improve provincial standards for prevention and control of infections in health care facilities. [5.8]	• AHS Single-Use Medical Device policy that aligns with the AHW standard was developed. • Legal review of draft policy complete. AHS is in alignment with the revised AHW Infection, Prevention and Control (IPC) Accountability and Reporting Standards.
Increase effectiveness of hand hygiene with implementation of hand hygiene policy/ procedure.	• Policy and Procedure approved October 2011 was disseminated across AHS and was made available to agencies that contract services to AHS (e.g., Continuing Care, Non-Hospital Surgical Facilities). • Education and promotional material on hand hygiene developed, approved and disseminated across AHS facilities and services. • Hand hygiene compliance performance measure to be developed in alignment with provincewide hand hygiene compliance review methodology.
Ensure infection prevention and control content is available in all health care settings and sectors to support clinical practice.	• Standardized education for AHS general orientation for all new staff developed and implemented. • Standardized Annual Compulsory Education on IPC basic practice and safe syringe use for AHS clinical staff developed and implemented. • AHS IPC webpage established with content that includes best practice recommendations, outbreak management, personal protective equipment, resources, respiratory hygiene, hand hygiene and IPC contact information.

In Summary: Patient Safety remained a high priority with a variety of initiatives being implemented. In particular, much work has been underway to share best practices across the province and develop standardized provincial approaches.

Work is underway to develop more robust performance measures to monitor and improve patient safety. One metric below indicates that more focused work is required to analyze the factors that have lead to *Albertans Reporting Unexpected Harm*, and to implement specific strategies to lower this measure. This will be a focus in the upcoming year.

PERFORMANCE MEASURE	2006	2008	209/2010	2010/2011	2011/2012 TARGETS
Albertans Reporting Unexpected Harm	13%	10%	9%	12.2%	9%

Sources: HQCA

This metric is based upon a survey conducted by HQCA. It is the percentage of people who respond "yes" to the question: "To the best of your knowledge, have you, or has a member of your immediate family experienced unexpected harm while receiving health care in Alberta within the past year." This includes care provided by all health providers including dentists, chiropractors, etc.; not just those providing care on behalf of AHS.

PERFORMANCE MEASURE	Q4 2010/ 2011	Q1 2011/ 2012	Q2 2011/ 2012	Q3 2011/ 2012	2011/2012 TARGETS
Infection Prevention and Control: **MRSA infection rate:** Hospital acquired methicillin resistant staphylococcus infection rate among patients admitted to: incidence of cases per 100,000 admissions.	0.19	0.17	0.22	0.15	Targets will be set following the collection of baseline data and of information on infection prevention and control program activity by AHS.
Surgical site infection rates: Rates of surgical site infections within 30 days of surgery.	Measurement strategy and targets are under development. Reporting for this indicator is anticipated to be available in Q2 2012-13.				

Sources: Alberta Health Services Infection Prevention and Control

Choice and Quality for Seniors

By 2030, one out of five Albertans will be more than 65 years old and the average age of Alberta's population will continue to increase. Many seniors will be more independent and healthier than in previous generations. Others, including those with multiple chronic illness and disabilities, will need health care and will want options that allow them to receive care while continuing to live in their own homes and communities.

More investment in home care and supportive living options will expand the choices available to seniors. Strategies that allow for a better service match to needs are also important for the overall sustainability of the system. With more options available and better access to caregivers, seniors will be able to live independently as long as possible.

PRIORITIES FOR ACTION: CONTINUING CARE

Provide Albertans with options to "age in the right place" by enhancing support services and offering more choice and care options to Albertans in their homes and communities.

ACTIONS	PROGRESS/RESULTS
With AHW, develop and start to implement a five-year continuing care plan, which will include a full range of living options [2.21]	• Significant work has continued with AHW to develop strategies and practices to better support Seniors. • The five zones have completed their capacity projections to 2030 including modifying their 5-year capacity plans to accommodate capacity projections to 2014/15 and added planning to 2016/17.
Expand community and long-term care by adding at least 2,300 continuing care spaces (2010-11 – 2011-12) to support seniors and people with disabilities. [2.1]	• 1,155 continuing care beds / spaces opened as of March 31, 2011. • 1,002 continuing care beds / spaces opened as of March 31, 2012. • The above additions have resulted in 2,157 of 2,300 target beds / spaces opened as of March 31, 2012. • Construction delays on two projects in Calgary resulted in delay of 239 beds / spaces; anticipate exceeding 2,300 target Quarter 1 2012-13.
Implement dementia care strategy, including supportive living beds. [2.15]	• 310 net new Supportive Living Level 4 - Dementia spaces have been opened as of March 31, 2012. • Provincial education for behavioral and symptom management using delirium protocol rolled out at Red Deer Regional Hospital and Medicine Hat Regional Hospital; Red Deer Regional Hospital designated NICHE hospital. • Draft Cognitive Impairment Strategic Framework presented to Cognitive Impairment Advisory Committee. • Over 1837 nurses and health care aides trained in dementia and delirium through Nursing Improving Care of Health System Elderly (NICHE) program. • Draft evidenced-based document developed to assist planning efforts for Supportive Living 4 – Dementia (SL4D); defining program elements required. • Evergreen of Supportive Pathways education completed (program designed to deliver dementia care training for Health Care Aides). • AHS Dementia Strategy vetted by Cognitive Impairment Advisory group; will require further consultation and chartering to mature into an initiative. • Developed and executed decision making capacity framework and piloted a training program for health care workers to enhance knowledge and skill in decision making processes at selected sites across AHS.
Develop quality mechanisms to ensure quality care is delivered. [2.23]	• AHS has provided extensive feedback on the Continuing Care Health Service Standards (CCHSS). AHW is planning another round of consultation in the spring of 2012. Once finalized, AHS will develop standardized CCHSS audit tools and companion guide (with AHW). • Some standardized components of the audit process have been developed. Planning is underway with Quality and Health care Improvement to develop an electronic system for monitoring and tracking compliance with standards. • Work is underway on priority policies and procedures in advance of CCHSS approval including home care, co-ordinated access, Alberta Continuing Care Information System (ACCIS) submission and high alert medication policies. • Safe Water Temperature Policy: Policy and procedure has been developed. An implementation plan has been developed and education materials are being piloted with front line staff.
Expand options for care to people who are disabled or have other special needs. [2.16]	• Currently completing an environmental scan on service gaps on young adults with disabilities. This review will enable provide a better understanding of the current service gaps and available funding options including self-managed care. The standardization practice on self-managed care is underway. • AHS is working with stakeholders across the province, and consulting with a medical ethicist, to develop an effective process for providing high-quality care and a wide range of supports for individuals who are disabled or have other special needs.

PRIORITIES FOR ACTION: **CONTINUING CARE**

Provide Albertans with options to "age in the right place" by enhancing support services and offering more choice and care options to Albertans in their homes and communities.

ACTIONS	PROGRESS/RESULTS
Ensure standardized assessment protocols and tools are consistently used.	• Alberta Health Services supports the use of the InterRAI Home Care (RAI-HC) Assessment instrument as a tool to measure clinical status and assist health care professionals to create a plan of care with the right mix of services to support an individual's abilities and lifestyle. • RAI-HC is used across Canada and around the world including in the U.S., Europe, Asia and Australia. It was developed by a panel of geriatric specialists and is regularly validated through ongoing review of millions of assessments each year. • The assessment process in not limited to a clinical measurement tool, however. It serves as a guide. The input of individuals, their families and physician, and the professional judgment of health care professionals is also important to ensuring the right care in the right place. • The assessment tool considers a broad range of physical, mental, and social abilities.
Work with AHW to test effectiveness of new technologies (e.g., monitoring and prompting devices) in two communities. [2.7]	• Three technologies have been tested (2 Personal Emergency Response Systems; and a medication management system) in two communities. • Test process included project plan, evaluations, round table discussions, final report and recommendations for policy development.

In Summary: AHS continues to add continuing care beds. In 2011-12, 1,002 beds were added to the system which now totals 2,157 additional beds; when combined with last year's 1,155 new beds. This was slightly below the anticipated increase in capacity due to construction delays. AHS is on track to add more than 5,300 beds between 2010 and 2015.

As noted in the chart below the substantial improvement that was made in 2010-11, in the number of people assessed and waiting was maintained, however this measure remained relatively unchanged in 2011-12. We anticipate this number will decrease as additional capacity is added and home care continues to expand.

Fewer people are waiting in the community for continuing care placement: 1,002 year-to-date, down from 1,115 over the same period last year, a 11 per cent improvement.

Of note in 2011-12 is the significant reduction in the number of days waiting for continuing care placement by 13 days. This number continued to be reduced in Q4 which will contribute to availability of hospital bed days.

During the next year considerable focus will be placed on improving this measure to both better utilize acute care facilities and ensure seniors and people with disabilities are supported in the most appropriate setting.

Number of People Waiting Continuing Care Placement (snapshot)

PERFORMANCE MEASURE	MARCH 31, 2010	MARCH 31, 2011	MARCH 31, 2012	2011/2012 TARGETS
Number of persons waiting **in acute/subacute** hospital bed for continuing care placement	707	471	467	375
Number of persons waiting **in community (at home)** for continuing care placement	1,039	1,115	1,002	900

Sources: AHS "Snapshots" of the Wait List at the end of the month

Wait Time for Continuing Care Placement

PERFORMANCE MEASURE	2010/ 2011	2011/ 2012	2015 TARGETS
Average wait time **in acute/subacute care** hospital bed for continuing care placement	54 days	41 days	30 days
Percent of patients placed **in continuing care** within 30 days of being assessed	55%	64%	90%

Sources: AHS Seniors Health and DIMR

PRIORITIES FOR ACTION: **HOME CARE**

Provide Albertans with options to "age in the right place" by enhancing support services and offering more choice and care options to Albertans in their homes and communities.

ACTIONS	PROGRESS/RESULTS
Expand availability of home care hours. [2.4]	• The approach to switch to unique home care client count has eliminated the risk of double counting clients, increasing accuracy and consistency in this measurement. • Home Care Redesign work is underway in partnership with AHW. Top priority projects include Adult Day Programs, Destination Home and 24/7 RN on Call. • Allocation of additional grant funding to support Self Managed Care (SMC) has been provided to zones as part of their based funding to support SMC clients in community. SMC is an alternate funding model available to eligible AHS Home Care clients for the provision of personal care and support services. • Implementation of "added care" to increase the number of eligible people for Home Care support.
Implement consistent home care policies and service package guidelines. [2.5]	• Home Care Service Guidelines have been approved with budget allocated to all rural zones to bring up the average service hours for long term Home Care clients to 120 hours per year. Zones are in the process of completing gap analyses to develop zone-specific strategies to implement the new Home Care Service Guidelines.
Increase and enhance education, care, respite and support services for family caregivers. [2.10]	• AHS launched a Caregiver Support and Enhanced Respite Demonstration Project in Edmonton in 2011. An evaluation of that project will be completed by the end of March 2012 and plans for provincial implementation will be developed. • The project aims to provide caregivers more respite time to allow them to accomplish other tasks important to them; to increase caregiver well-being; and to share information with caregivers about community support services.
Enhance options for palliative care to better support the end-of-life needs of seniors. [2.14]	• A Primary Care Network (PCN) demonstration project was implemented in partnership with Wood Buffalo PCN to care for clients at end-of-life in their own homes. Learning Essential Approaches in Palliative Care (LEAP) training was provided to volunteers, home care professionals and PCN staff. Purchased equipment and supplies for palliative clients in the home. PCN demonstration project completed March 31, 2012. • A hospice review was conducted with seven hospice providers regarding the state of hospice care: successes, barriers and gaps of hospice care in respective settings. Evaluation and recommendations in development. • Family caregiver support in palliative and end-of-life care project completed; developed comprehensive set of informational materials and resources for family caregivers to support their own personal health and well being while caring for someone at end-of-life.
Implement falls prevention program	• The CHAPS Program (Community Health and Pre-Hospital Support) utilizes EMS practitioners to identify individuals living in the community who may need home care or other services to lower their risk of falls and/or deteriorating health. An assessment tool is used to assist in identifying at-risk individuals. Pilot projects in Calgary, Edmonton and Parkland County showed the program reduced the number of repeat EMS calls and emergency department visits by individuals referred by EMS to Home Care. The program has been rolled out across the province. • The CHAPS Program is part of the larger "Emergency to Home" (ED2Home) project. • Develop a community support referral program: The CHAPS provincial roll-out has been completed. All services received the CHAPS referral form and the training material was posted on the provincial staff website in December 2011. Referrals are currently being submitted from all areas of the province.

In Summary: Home care is recognized as a critical component of the health system to enable people to remain in the community and close to home. Over the past year, much effort has been focused on strengthening the foundation of the home care program, so that continued expansion of services can occur in the most efficient, effective and safely manner. During the next year, continued expansion will occur to shift more resources from to the community. In addition, work will be undertaken to establish appropriate measures and targets which can be utilized to monitor success of home care initiatives.

This expansion and focus on home care will continue in the next year to enable individuals to be supported in the community, to facilitate hospital flow, and to better support end-of-life care. More seniors and adults with disabilities are able to remain safe and independent in their own homes as AHS added more than 4,400 home care clients year-to-date, a 4.4 per cent increase. This also exceeds our target of 3,000 additional clients by March 2012.

Number of Home Care Clients

PERFORMANCE MEASURE	2010/2011	2011/2012	2011/2012 TARGETS
Number of unique home care clients	100,277	104,704	Increase by 3%

Sources: Reporting methodology for number of home care clients has changed from previous years. Currently, the approach to switch to unique home care client count has eliminated the risk of double counting clients, increasing accuracy and consistency in this measurement.

Enabling Our People/Enabling One Health System

The performance of our health care system is directly related to the people who provide care and services to the citizens, families and communities we serve. Alberta Health Services is committed to enabling our staff and physicians to provide high quality and safe care by providing the appropriate supports, such as; education, an attractive and safe work environment and the required tools. To move to higher levels of performance, a shared culture will be developed based on the AHS's values of respect, accountability, transparency, engagement, performance, safety and learning.

Alberta Health Services must engage all staff and physicians if we are to realize our Vision and develop a patient-centred culture. We will only be as good as we can when we have meaningful engagement. Change management support will guide health providers to be truly focused on the needs and goals of patients and their families. In addition, AHS has a responsibility to prepare our people to meet the future needs of an evolving health system and an increasingly sophisticated and knowledgeable public.

Alberta Health Services is the result of the largest merger in Canadian history. AHS is committed to developing administrative support systems and procedures that enable staff and physicians to provide excellent health care services to patients, families and communities. The consolidation of a large number of former health care entities is a significant undertaking that requires proper planning and determined execution. The delivery of high quality, safe health care services depends on efficient and effective supports.

PRIORITIES FOR ACTION: HEALTHY WORKFORCE

Efficiently utilize health professionals by matching workforce supply to demand, promoting team-based delivery of services, and allowing health providers to work to the full extent of their education, skills and experience.

ACTIONS	PROGRESS/RESULTS
Complete staff and physician compensation/benefits/rewards and recognition program.	• The President's Excellence Awards recognizes Alberta Health Services staff, physicians with privileges and teams who demonstrate innovation, collaboration and patient focus, and exemplify the AHS values of respect, accountability, transparency, engagement, safety, learning and performance. The three awards categories include: • The President's Excellence Award for Outstanding Achievements in Quality and Safety Improvement, which recognizes individuals or teams who have worked to improve health care quality by demonstrating commitment and implementing or redesigning a service or process which achieves exceptional improvements to: patient safety; patient experience; patient health outcomes and/or organizational or clinical effectiveness. • The President's Excellence Award for Outstanding Achievements in Workplace Health and Safety, which recognizes individuals or teams who have succeeded in creating a safer, healthier work environment by implementing a new, unique, forward-thinking idea that improves workplace health and safety. • The President's Excellence Award for Outstanding Achievements in Research, which recognizes a project or initiative which harnesses the collective efforts of Alberta Health Services staff and physicians together with research and academic partners. The partnership will be innovative, use collaborative problem solving or practice in the delivery of effective clinical care, and show how research translation has contributed to improved outcomes for staff and/or patients. • Representatives of AHS committees and Dr. Eagle reviewed all submissions and selected their top five submissions in each category. The Quality and Safety Improvement, and Research categories were judged by representatives of the Clinical Strategic Executive Committee. Representatives of the Alberta Clinician Council judged the Workplace Health and Safety category. • Award recipients were announced in May 2012.

Develop a staff and physician learning and development strategy. [5.1]	• AHS Learning and Leadership teams offer a wide range of supports and services for learning and development.
	• For Employees:
	  • MyLearningLink– your gateway to AHS learning opportunities.
	  • Organizational Orientation– for all new AHS staff.
	  • Annual Continuing Education– resources to help staff meet annual education requirements.
	  • Basic Life Support (CPR) training – based on Heart and Stroke Foundation guidelines.
	  • Open Sessions– professional development sessions on a range of different topics.

PRIORITIES FOR ACTION: HEALTHY WORKFORCE

Efficiently utilize health professionals by matching workforce supply to demand, promoting team-based delivery of services, and allowing health providers to work to the full extent of their education, skills and experience.

ACTIONS	PROGRESS/RESULTS
Complete clinical workforce strategy and recruitment plan, including staff, physicians and other health professionals. [5.3, 5.4]	• Clinical workforce strategic plans were completed in March 2012 for each of the five zones to guide implementation of strategic workforce initiatives within their local context. These plans are aligned with the Zone Integrated Operational Plans (ZIPs). Cancer Care clinical workforce planning also has commenced. • At the end of the 2011-12 fiscal year AHS has an additional 3,721 employees (2,684 FTE) in the clinical workforce over 2010-11 fiscal year end. • Alberta Health Services hired 1,652 (> 98 per cent) new nurse graduates available this fiscal year (2011-12). Of these, 1,038 (63 per cent) were hired into regular (non-casual) positions. This represents an improvement over the previous fiscal year. Resources are developed and being implemented to support the successful transition of new graduate nurses into the workplace including tools for the new employee, managers, educators and staff. 100 per cent of the new grads exposed to the tools have been retained to date. • Calgary Zone initiated a number of hiring initiatives related to the opening of the South Health Campus (SHC), including direct hiring to SHC positions and anticipatory hiring to all sites, resulting in 550 new hires, and over 1,000 postings in March 2012. • Since August 2011, AHS has placed 3,110 career advertisements in a variety of media including print, online job boards and social media. AHS staff attended 121 career events, including 37 outside of Alberta and five international. • Workforce Model Transformation commenced at three acute care sites in January 2012. The focus is role and team optimization within collaborative practice teams while improving quality of patient care with future models being determined for rollout by July 2012. • A provincial working group is formed to address issues related to recruitment of mental health staff. • Negotiations with UNA to improve and revitalize the Transitional Graduate Nurse Recruitment Program as a proven mechanism for recruiting and retaining new grads have been successfully concluded.
Establish a framework to facilitate effective participation of physicians and physician leaders in AHS accreditation activities.	• Developed a framework for physician engagement which details forms of involvement for physicians in accreditation activities, including participation in Standards and Required Organizational Practices teams as well as aspects of logistics and communications required to support their engagement. • A web page pertaining to accreditation opportunities will be set up for physicians on various teams throughout the province. • The Medical Director, Accreditation and the Vice President, Quality Stewardship will participate in presentations with each zone to discuss physician participation in accreditation activities.
Develop an AHS physician communication strategy that includes two way communications.	• A provincial Medical Affairs Communications Framework has been approved by the Chief Medical Officer portfolio. • Recruitment to the Practitioner Communications Advisory Group is currently taking place.
Implement workplace health and safety management system.	• Implement leaders' certification and mentoring programs: Safety modules for AHS leaders have been developed. Workplace Health and Safety learning and training activities related to asbestos awareness; incident investigation; hazard identification and control; workplace inspections and/or corrective action have been launched. "It's Your Move", a program that promotes safe handling of patients and clients, has trained more than 3,700 individuals. • Implementation of WHSMS: Noise Management Program, First Aid Code of Practice and Critical Incident On-Call Process implemented.
Implement healthy workplace action plan.	• The Workplace Health and Wellness Action Plan outlines the approach and plan to Alberta Health Services workplace and employee wellness, and is intended to complement the AHS Strategic Plan for Workplace Health and Safety. While the strategic plan sets the foundational direction for AHS workplace health and safety culture, system and resources, the Workplace Health and Wellness Action Plan focuses on how AHS can optimize the conditions needed for our people to thrive on the job. Implementation of the Action Plan will contribute to the AHS goal of becoming a "workplace of choice" in Alberta.
Implement professional development in health, safety and wellness for health workers. [5.2]	• A comprehensive *Shared Responsibility Framework for Health, Safety and Wellness in the Workplace* was established to reinforce the new AHS Safety Value. Workplace Health and Safety improvement plans are 90 per cent developed and implementation is well underway for 2011-12.

In Summary: Ensuring the AHS workforce is supported, and their skills are utilized in the most appropriate and efficient way is of utmost importance to AHS. Continued efforts have resulted in recruiting the vast majority of RN graduates. The ratio of full-time equivalent to headcount showed significant improvement and has surpassed the 2011-12 target. Continued work is also required ensuring we have the right workforce to meet the needs of our health system, and that our disabling injury rate is reduced.

PERFORMANCE MEASURE	2009/2010	2010/2011	2011/2012	2011/2012 TARGETS
Ratio of full-time equivalent (FTE) to headcount. This measure supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.	1.57	1.57	1.55	1.62
Percentage of Alberta university/college Registered Nurse graduates hired by Alberta Health Services. *Total includes casual and non casual; non casual includes full-time and part time permanent and temporary.*	Data not previously collected	Total = 87% Non Casual = 41%	Total = > 98% Non Casual = 67%	70%
Disabling injury rate (staff injury rate) per 100 workers.	2.83 (2009)	3.19 (2010)	3.36 (2011)	2.2

Sources: Alberta Health Services Human Resources

PRIORITIES FOR ACTION: **ENGAGEMENT**

Enhance staff and physician satisfaction.

ACTIONS	PROGRESS/RESULTS
Develop and implement strategy to improve workforce/physician engagement based upon feedback received.	• Physician Advocacy Assistance Line implemented on January 2012. • Working Group hosted Physician Advocacy Planning Session held in February 2012 with attendance from University of Calgary, medical school, Professional Association of Resident Physicians of Alberta, Alberta Medical Association. They jointly identified current activities and future programs that support Physician Advocacy.

Implement initiatives that foster a just and trusting culture and enhance experience, as well as attract and retain top quality staff and physicians.	• Development of Provincial Recruitment Strategies that include:
	  • Targeted Recruitment Plans for hard to recruit practices or specialties
	  • Development of recruitment tools and information materials for zone recruitment activities
	  • Development of Physician Postings section to AHS recruitment site by March 2012
	  • Development of Provincial Client Management Database.

In Summary: The Alberta Health Services (AHS) 2012 Workforce Engagement Survey was launched in March 2012. The survey helps AHS to understand the level of engagement that employees, physicians and volunteers have in a number areas at the local and organizational level. The results below indicate a considerable improvement has been made in the level of engagement for staff, physicians and volunteers.

Overall, 53 per cent of staff, physician and volunteers who participated in the survey are favourably engaged, up significantly from 37 per cent recorded in a similar survey conducted in early 2010. An increase in favourable engagement scores was seen in each of the three population groupings. Efforts will continue to further increase engagement levels across the organization.

PERFORMANCE MEASURE	2009/2010	2011/2012	2011/2012 TARGETS
Staff and Physician Engagement Percentage of Favourable:			
Overall engagement score: Employees, Physicians and Volunteers	37%	53%	54%
Staff	35%	52%	54%
Physician	26%	39%	54%
Volunteer	79%	85%	54%

Source: 2012 Employee Survey (Talent Map Engaging Employees Survey)

PRIORITIES FOR ACTION: INFORMATION TECHNOLOGY AND INFORMATION MANAGEMENT

Improve the quality and cost-effectiveness in health care service delivery through electronic management and use of medical information.

Put in place the consolidated systems and capabilities to create a sustainable operating environment for AHS. Systems range from Human Resources / Payroll and Finance to Clinical Information and Reference systems.

ACTIONS	PROGRESS/RESULTS
Review and update the IT Strategy, with input from stakeholders, to reflect updates to AHS directions.	• The IT Strategy and the Health-System Five Year IT Plan are undergoing updates to reflect changing business and clinical priorities. Updates are ongoing through consultation with stakeholders within and outside of AHS.
Implement and consolidate major business systems in the area of information technology for business and clinical areas. [5.29]	• EMS ePCR application rollout to all AHS EMS direct delivery ground providers is complete, including areas that recently transitioned to AHS (Cardston, Claresholm). • In-vehicle charging standard determined and implemented to all Inter-facility Transfer (IFT) vehicles in North IFT to meet timeframes for their rollout. All other AHS EMS vehicles are being modified as required to meet the standard as they are brought in for other maintenance or inspection. • Air Ambulance/critical care ePCR configuration session held (with participation from AHS EMS, STARS and the vendor); the project team continues to meet weekly to refine detailed ePCR requirements • EMS ePCR team completed the rollout of the Phase III point of care application to all AHS operated EMS areas. ePCR is the first clinical truly provincial application. An average of 860 EMS patient care reports daily go through the system. • Enterprise Master Patient Index (EMPI): All data for North, Central, South Zones and Cancer Care has been loaded into AHS EMPI. Cross matching of this new AHS EMPI data has been completed.
Work with Alberta Health and Wellness to encourage more health care providers to use the province's electronic health record system to input and access patient information electronically instead of manually. [5.20]	• Alberta Netcare is a program that encompasses all the projects, processes, products, and services that work together to make Alberta's Electronic Health Record (EHR) a reality. It has been developed by AHW in cooperation and partnership with AHS and many other partners including the health professional colleges and associations. • Most zone home care areas are now actively using Netcare to access data sources already published. For the Alberta Netcare Release planned for November 2012, the data source of "Seniors Health Community Client Profile" (a patient summary) is planned for publication from all AHS zones (currently only published for the Edmonton Zone). • Work continues in conjunction with AHW on the revitalized marketing campaign to update all Alberta providers on the data available in Netcare and the benefits of usage to date.
In collaboration with AHW, add electronic diagnostic imaging records to the provincial electronic health record. [5.21]	• Provincially, 86% of all rural private radiology clinic images are being submitted to the North/South diagnostic imaging repositories: North Repository - 79 per cent; South Repository - 93 per cent. Work in progress to complete integrations for remaining private radiology clinics.

The Phase 1 IT Security Initiative was the first dieliverable in the AHSecure Program. In 2011-12, the AHSecure Program will continue with several other initiatives, including the first major deployment of identity and access management, secure email deployment and IT risk management framework.	The mandate of the AHSecure Program is to:
	• Identify, prioritize and resolve the security deficiencies that exist in AHS and
	  • Further improve the security posture of AHS through the implementation of controls, awareness training and the publication of security policies.
	  • AHSecure Intitiatives Program include: Active Directory, Anti-Virus and Endpoint Protection, Baseline Maturity Assessment, Cryptographic Controls, Firewall Consolidation, Identity and Access Management, IAM Integration, IP Readdressing, IT Control Framework Implementation, Network Access Control, Roaming and Cross Entity Access, SCR Implementation, Secure Email, Security Documentation, Security Incident and Event Monitoring and AHSecure Branding.
	  • The AHSecure Program continued throughout the year. There were several security awareness messages developed and distributed to staff throughout the year, and an updated security awareness program was deployed in conjunction with Information and Privacy.
	  • The first deployment of Identity and Access Management was successfully delivered, integrating the HR and network account systems. Secure email was delivered and is in production. The IT controls framework self-assessments were completed and work continued throughout the year to finalize the controls framework, which will be approved and released in Q1 2012-13. New policies and procedures were developed to improve the overall security maturity for AHS.

Complete IT roadmaps to facilitate the identification of IT initiatives and priorities..	• IT Leadership is working with zone, provincial program, clinical support and corporate service department leadership to directly align IT initiatives and priorities with business and clinical priorities. This work incorporates assessment of capacity and change impact to ensure that priority initiatives are structured for success. Conflicts in priority and situations of resource contention will be resolved by working with senior leadership.

PERFORMANCE MEASURE	2009/2010	2010 / 2011	2011 / 2012	2011/ 2012 TARGETS
Information Technology and Information Management:				
Alberta Netcare: Number of physician and nurse users who access the Electronic Health Record system across the continuum of care.	10,067 peak quarter	11,816 in Q4 17% increase	14,605 in Q4 24% increase	+10% increase from 2010-11
Alberta Health Services Information Technology Strategy: Consolidate, Unify, Optimize. Move to common systems for all of AHS needs to provide standardization around common processes, tools and information.	Email system, networks and IT services consolidated and optimized.	Financial systems consolidation process achieved.	Completed HR/Payroll and Financial systems consolidation. Significant consolidation towards 2 systems. Interactive Continuity of Care Record was extended. Completed blueprint for common clinical information systems.	Complete HR/Payroll and Financial systems consolidation Replace 24 systems replaced with 2 systems. Extend Interactive Continuity of Care Record. Complete blueprint for common clinical information systems.
Alberta Health Services Information Technology Strategy: Reduction in AHS Information Technology operating budget support consolidation of systems and infrastructure.	Budget was $213 Million.	The targeted savings was $10 Million.	There was a savings achieved of $7.9 Million.	-5% decrease from 2010-11

In Summary: Numerous IT initiatives continue to be implemented on a provincewide basis. Investment in technology is critical to enable a high functioning, safe, efficient health system and this will continue to be advanced in a co-ordinated and prioritized manner.

PRIORITIES FOR ACTION: **FISCAL EFFICIENCIES**

Employ fiscal efficiencies to ensure fiscal responsibility and good stewardship of resources. Reduce duplication and streamline processes to improve efficiencies.

ACTIONS	PROGRESS/RESULTS
Develop new operating budget process. Implement and consolidate major business systems in the areas of finance, human resources, data management and purchasing. [5.29]	• Originally called the Finance/CPSM Optimization program, e-Accounts is the new name for the program which is working to consolidate numerous Finance and Contracting, Procurement and Supply Management (CPSM) initiatives. • The goal of this program is to review, refine and enhance the current AHS Finance and CPSM systems to make effective and useful financial and administrative tools available to those who rely on these systems every day. • The e-Accounts website is the central location for all information related to AHS Finance and CPSM systems. • For those who use these systems every day, the e-Accounts program includes accurate, timely and responsive processes for procurement, budgeting, forecasting and payables. • e-Accounts is a single access point to systems such as Markview, Management Reporting and i-Procurement among other programs. It will also be the central source for information relating to the improvements and enhancements that are being made to these systems. • e-Accounts' systems impact every area and department within AHS and ultimately support our goal to provide high-quality patient care to Albertans. • We've already made significant progress in creating systems that have greater capacity and enhanced capabilities. We've also defined the overall project outcomes for the front-line users and determined exactly what changes have already been completed as of the end of March 2012.
Procure to Pay (P2P) system installed. Install Budgeting and Management Reporting System.	• The P2P Project will deliver a single province wide finance and supply chain application that will eliminate dependencies on disparate regionally based systems, while the Management Reporting Project will focus on integrating a new consolidated management reporting solution. P2P phase 1 went live in February 2011. • Budget and Planning Project is to provide AHS with a single budgeting and planning solution that will bring greater consistency, accuracy and transparency to our financial planning processes. The implementation of Oracle's Hyperion suite of products will be carried out in a phased approach beginning with the implementation of budgeting. Business Advisory Services (BAS) representatives will use the Hyperion Planning application for your budgeting, planning and forecasting, as well as for other reporting, and analysis of drivers and costs of services implemented in November 2011. • Human Resource/Pay Consolidation Project – Phase I: The implementation of e-People for former Capital Health and AADAC employees implemented October 2011. Detailed planning for the rural zones including implementation of the required scheduler continues.
Complete capital projects reconciliation by year-end audit on time.	• AHS is collaborating with Alberta Infrastructure and AHW to define the various roles and responsibilities during the life cycle of major health capital projects; from planning through to construction and operational commissioning. Work has commenced on the re-writing of the Health Capital Projects Manual, which will document and provide a guide for the development of capital projects.
Implement and further expand patient-based funding methodology.	• Alberta Health Services began implementing Patient-Based Funding (PBF) in Long-Term Care (LTC) in April 2010. • Data are being collected to allow implementation of PBF in bed-based supportive living. • Approaches to introducing PBF for acute services are being developed.

In Summary: The financial summary can be found in the Financial Overview of this document.

PERFORMANCE MEASURE	2011 / 2012	2011 / 2012 TARGETS
Adherence to Five-Year Budgeted Government Funding: AHS will operate within the approved five-year funding agreement with the Government of Alberta, and will not record an accumulated deficit at the conclusion of this period as recorded in the overall Alberta Health Services audited financial statements. Surplus/(Deficit).	The accumulated surplus at March 31, 2012 is $82 million which is within 1.5 per cent of the annual funding agreement ($145 million)	Variance no greater than + or - 1.5 per cent of the annual funding agreement

Foundational/Organization-wide

There are a number of other actions and measures that relate to the overall development and functioning of Alberta Health Services that will help us advance our goals. Although many of these foundational actions have been described in other sections of this document, there are performance measures designed to help ensure we are improving overall patient satisfaction with services, that we are fulfilling our reporting obligations to the government, that we are engaging our communities and that we are improving the quality of our services through accreditation mechanisms.

PRIORITIES FOR ACTION: PATIENT-FOCUSED SYSTEM

Deliver a patient-focused system that captures patient perspectives on care and services received so as to improve health system quality and responsiveness to patient needs. Increase patient satisfaction with the care and services received.

ACTIONS	PROGRESS/RESULTS
Use the provincial Feedback and Concerns Tracking System (FACT) implemented March 31, 2011, to monitor results and further develop plans for improvement.	Feedback and Concerns Tracking System Module Update: • Responding to patient feedback is a responsibility of all staff, management and practitioners. The Patient Relations (PR) Department receives comments and concerns from the public which provide unique information about their experiences and the quality of care they receive. The role of PR is to inform and support quality patient care by listening and responding to their feedback, guided by the legislated Patient Concerns Resolution Process. • Patient Relations provides quarterly reports to the AHS Board, senior executives, and operational and practitioner leaders as available. In the first quarter of the 2011-12 fiscal year, PR has tracked and reported on 233 commendations and 2,216 concerns. The patient stories help to inform what issues are being raised in combination with the performance measurement data reported for Tier One Measures.

Develop and implement a patient engagement framework and establish the AHS Patient and Family Advisory Council.	• The Patient and Family Advisory Group is a formal collection of volunteer patients and families from across Alberta who together brings a richness based on the diversity of their location, age, gender, background, culture and patient/family health service-related experiences, to their role as patient/family advisors.
	• The work of the group is based on the values of partnership, collaboration, engagement, respect, transparency, and a foundation of ensuring that health care services are patient and family-centred.
	• The purpose is to advise AHS, its senior leaders, health care providers, staff and physicians on policies, practices, planning and delivery of health care services from the patient/family perspective.
	• Specific areas of group involvement may include:
	  • advising on professional practice and service redesign projects and initiatives to ensure the patient voice is incorporated;
	  • advising on patient/family-centred care principles;
	  • assisting in educating both staff and the public around patient/family-centred care principles and practices;
	  • representing a strong patient voice advocating for patient/family-centred care and patient engagement throughout the organization.

In Summary: AHS works closely with HQCA (Health Quality Council of Alberta) to monitor patient satisfaction. Over the past fiscal year, many initiatives have been implemented to improve patient satisfaction; however the impact of these initiatives is not yet known.

PERFORMANCE MEASURE	2010 / 2011	2011 / 2012	2011/ 2012 TARGETS
Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year. *Source: HQCA Satisfaction*	62% (2010)	Work is currently underway on the 2012 survey	66%
Acute Care – Hospital Services: Percentage of patients rating hospital care as 8, 9, or 10 on a scale from 0-10, where 10 is the best possible rating. *Source: AHS Provincial H-CAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems Survey)*	82%	84.1% (April – Dec 2011)	80%
Continuing Care: Long-Term Care Facilities: Overall **family** rating of care at nursing homes, on a scale from 0 to 10. *Source: HQCA* Overall **resident** rating of care at nursing homes, on a scale from 0 to 10.	71.0% (2007/2008) 73.4% (2010/2011) 8.0 (2010)	Work is currently underway on the 2012 survey No HQCA Survey Planned	TBD
Assisted Living Home Care	Work Ongoing		Planning stage to March 31, 2012
Emergency Department Care – Past Year: Percentage satisfied or very satisfied with their or a close family member's services at an emergency department in past year.	58% (2008) 59% (2010) *(Source: HQCA)*	Adult = 68% Pediatric = 82% *(Source: AHS H-CAHPS)* Apr. – Dec. 2011	TBD
Emergency Department Care – Within three weeks of receiving the service: Percentage rating emergency department care as excellent or very good within three weeks of receiving the service.	65% *(Source: HQCA)*	No HQCA Survey Planned	TBD
Emergency Medical Services (EMS)	Work Ongoing	Developed and pilot of survey	Implementation in 2011-12
Mental Health Services: Percentage of Albertans satisfied or very satisfied with the mental health services they received. *Source: Health Quality Council of Alberta. Satisfaction with Health Care Services: A Survey of Albertans 2008 and 2010.*	74% (2008) 78% (2010) *(Source: HQCA)*	92.3% *(Source: AHS)*	TBD

PRIORITIES FOR ACTION: **GOVERNANCE**

Alberta Health Services demonstrates good governance.

ACTIONS	PROGRESS/RESULTS

Further refine strategy cycle in conjunction with AHW.	• AHS has developed a strategic planning cycle that supports a whole system approach, and aligns with AHW requirements. This allows for the integration of requirements for capital and finance planning, and appropriate time allotment for other related planning, development and approval processes.
	• Further strengthening of the plan will incorporate the following components:
	  • Health needs assessment (with increased focus on a geographic approach)
	  • Population health
	  • Value assessment and prioritizing investments
	  • Whole system planning approach
	  • Further focusing of the priorities

[5.1] Timely submission of AHS Board-approved Business Plan and a Health Plan to the Minister of Health and Wellness.
[5.2] Timely quarterly reports are submitted to the Minister of Health and Wellness.
[5.3] An Annual Report in accordance with Ministry requirements is submitted to the Minister.
[5.4] Audited financial statements in accordance with Ministry Financial Directives are submitted to the Minister.
[5.5] AHS Board annually submits its findings of a self-assessment of Board performance, with actions to improve governance and quarterly updates on progress achieved.
	• AHS has worked with AHW over the past year to develop according to the prescribed format and submitted on or prior to the submission deadlines:
	  • Quarterly performance reports,
	  • Quarterly financial reports,
	  • 2012 - 2015 Health Plan and Business Plan; and
	  • Annual Report with audited financial statements in accordance with Ministry Financial Directives.
	• These documents have been co-ordinated with AHW to ensure alignment with AHW Direction.

PRIORITIES FOR ACTION: **COMMUNITY ENGAGEMENT**

Effective community engagement and public consultation that supports effective planning, delivery and evaluation of health services.

ACTIONS	PROGRESS/RESULTS
[5.6] AHS Health Advisory Councils are to submit an annual report to the AHS Board describing community needs and AHS's responsiveness to community needs. This annual submission by AHS Community Advisory Councils is to be delivered to the Minister.	• The mandate of the Health Advisory Councils is to support AHS in achieving its strategies by engaging residents and providing advice and feedback from a local perspective on what is working well in the health care system and areas in need of improvement in communities across the province. All council members are appointed by the AHS Board. • During the second year of operation, the councils were more established in their communities and hosted a number of community consultations held with Albertans to provide AHS with more feedback on the local perspective surrounding health care delivery in communities across the province. As councils become better known in their communities, greater opportunities for engagement present themselves amongst community members and organizations. Council members have taken the feedback and comments from these community consultations to inform their dialogue with Alberta Health Services senior leaders. • The councils continue to provide feedback on several fronts for Alberta Health Services which assist in planning processes and strategic development. Several AHS planning initiatives were reviewed by councils and advice was provided to support the work. Examples include Zone Improvement Plans, Just Culture, Community and Rural Health Planning, Emergency Medical Services, Medication Reconciliation Project, Concierge Customer Service Initiative, Health Link, organizational realignment, and many aspects of local health care services throughout the province. • Members of the Alberta Health Services Board continue to be informed about council activities and issues which are being addressed with operational leaders as well as their perspectives on health care. Board members also attend council meetings throughout the province on a regular basis to become more aware of the work of councils and learn directly about health care services and opportunities for improvement.
Hold Health Advisory Council meeting in 2011-12.	• The second annual Health Advisory Council provincewide meeting was held in Calgary and provided the opportunity for council members to further engage with AHS Board Members and members of the Executive Committee while learning more about engagement and communication techniques to improve their work in communities.
Establish provincial advisory councils in support of Cancer Care and Addiction and Mental Health.	Provincial Advisory Council on Cancer • The Provincial Advisory Council on Cancer was established by the Alberta Health Services Board in April 2011 and following recruitment and member appointments, the council held two meetings. The meetings were attended by members of the Alberta Health Services Board and Executive. Several initiatives/projects underway within the Alberta Health Services Cancer Care system were reviewed with the council members to assist them in developing future priority areas for their consideration. Members were consulted on the proposed Alberta Cancer Plan and provided valuable input. Council members initiated development of their work plan for the coming year. Provincial Advisory Council on Addiction and Mental Health • The provincial Advisory Council on Addiction and Mental Health was established by the Alberta Health Services Board in December 2011. A recruitment process was completed to fill the 15 council positions. The Alberta Health Services Board will appoint members early next year and it is anticipated that the inaugural meeting of this council will be held prior to the end of June 2012.
Create work plans for all councils, including mechanisms councils will adopt for engaging the communities they represent.	• Each Health Advisory Council completes annually a work plan as well as an annual report that is submitted for review to the AHS Board Health Advisory Committee. • The 2011-12 Health Advisory Council work plans and annual reports are posted on the AHS website.
Establish website on community engagement which will host useful information for Foundations and Health Trusts.	• Alberta Health Services relies on its 64 Foundation and Health Trust partners to help drive innovation in health care. These organizations work diligently to gather community support, develop partnerships and raise critically-needed funds to further enhance the care delivered to patients and families in Alberta. They are committed to building excellence within our system. • A list of Foundations and Health Trusts by zone and across the province is posted on the AHS website.
Disseminate community engagement framework. The methodology of how to engage the community will be available through multiple channels for all staff.	• The AHS Engagement Framework was developed in 2011-12 pending Executive approval. • AHS is committed to local decision-making and key to this in engaging our stakeholders. The Engagement Framework and Policy provide a comprehensive approach for engagement of stakeholders. The Engagement Framework and Policy are accompanied by an online engagement toolkit for use across Alberta Health Services to enhance our capabilities and competency to engage. • Engagement Framework and Policy supports leading practices for health care systems in an easy to follow approach including a roadmap, a toolkit and the alignment of stakeholder engagement processes across Alberta Health Services, thus enabling the capacity within AHS to perform engagement at the highest standard possible.

PRIORITIES FOR ACTION: **ACCREDITATION**

AHS undertakes accreditation activities in compliance with the Minister's directive on mandatory accreditation.

ACTIONS	PROGRESS/RESULTS
[5.7] AHS and all contracted operators maintain acceptable accreditation status from accrediting organizations deemed acceptable to the Minister. Participate in the College of Physicians and Surgeons of Alberta accreditation of diagnostic programs, including Laboratory Services, Diagnostic Imaging, Neurophysiology and Pulmonary Functioning.	• The Accreditation Department compiles information on internal AHS accreditation (Accreditation Canada, CPSA for Diagnostic Imaging and Laboratory) and accreditation for external services (contracted clinical services for EMS, Seniors Health, Addictions and Mental Health); funded providers (Covenant Health, Lamont Health Care Centre). • Ongoing support to the portfolios and their contracted providers in understanding accreditation requirements (EMS, Seniors Health, Addictions and Mental Health).
Undertake accreditation activities.	• 61 locations were assessed during the on-site survey. All sites and services offered by the organization are deemed accredited. • The following sets of standards were used to assess the organization's programs and services during the on-site survey. • Population-specific Standards: Child and Youth Populations, Maternal/Child Populations and Cancer Populations. • Service Excellence Standards: Critical Care Services, Obstetrics/Perinatal Care Services, Surgical Care Services, Emergency Medical Services, Cancer Care and Oncology Services, Emergency Department Services and Operating Rooms.
Participate in Accreditation Canada's accreditation process and work within the provincial standards framework.	• AHS participated in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in October 2011. • AHS was commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.
[5.8] AHS submits an accreditation report annually.	• AHS was awarded "Accreditation with Condition" by Accreditation Canada for the second consecutive year. • 20 Accreditation Canada surveyors visited 61 facilities October 3 – 7, 2011. AHS services were compared to national standards for cancer care, critical care, emergency department, obstetrics, operating rooms and surgery, and provincial services for mothers and their babies, children and youth and persons at risk for cancer. • AHS met 89 per cent of the total criteria, with 11 per cent criteria determined to be unmet. This was a great achievement for a large organization. Services that have unmet criteria may be very close to achieving these standards; however, there is some further work to be done to fully meet or exceed Accreditation Canada criteria. AHS will report on progress to Accreditation Canada in June and December of 2012. • The Accreditation Canada Report states that the "strengths of AHS include an enormous amount of very good work in developing foundational strategies, plans, policies and other initiatives which will serve as a strong basis for moving forward. AHS is well poised to now move from strategy development to implementation." • AHS is proud of its caring, compassionate and knowledgeable physicians and staff and its committed and dedicated volunteers. We are pleased to hear that our patients feel safe, prepared and informed. • AHS has a number of initiatives underway to improve patient safety and quality of care. Specifically, AHS will target and report back to Accreditation Canada on: educating patients and families on their role in promoting safety (e.g. brochures, videos); appropriate and timely transfer of information so that patients receive the best care possible (e.g. at shift changes, when transferring to another facility or service); determining what is a "high-risk" activity or service and putting strategies in place to reduce risk (e.g. surgery checklists); annual staff training on the use of intravenous pumps; and learning from "good catches" and "adverse events" to increase patient safety. • AHS looks forward to the next Accreditation Canada survey of several AHS facilities across the province against national quality standards in October 2012. The focus will be on medicine services (rural acute medicine and renal medicine), brain injury, rehabilitation, addictions and mental health, chronic disease and seniors' health.

Financial Statement Discussion and Analysis For the year ended March 31, 2012 (in millions of dollars)

Purpose

This Financial Statement Discussion and Analysis (FSD&A) is provided to enable readers to assess Alberta Health Services's (AHS's) results of operations and financial condition for the year ended March 31, 2012 compared to budget and to the preceding year. In particular, the FSD&A reports to stakeholders on how financial resources are being managed to provide appropriate access to quality, sustainable health care services.

This FSD&A has been prepared by management and should be read in conjunction with the March 31, 2012 audited consolidated financial statements, notes and schedules. The consolidated financial statements are prepared in accordance with Canadian generally accepted accounting principles and Financial Directives issued by Alberta Health and Wellness (AHW). All amounts are in millions of dollars unless otherwise specified.

AHS financial statements are prepared on a consolidated basis and include the following:

- Three wholly-owned subsidiaries: Calgary Laboratory Services Ltd., Capital Care Group Inc., and Carewest;
- 50% interest in the Northern Alberta Clinical Trials Centre joint venture with the University of Alberta;
- 50% interest in the 40 Primary Care Networks (PCNs); and
- Provincial Health Authorities of Alberta Liability and Property and Insurance Plan (LPIP).

Additional information about AHS including financial reports from prior periods is available on the AHS website at www.albertahealthservices.ca.

Overview of 2011-12

The following table summarizes the Consolidated Statement of Operations:

STATEMENT OF OPERATIONS	BUDGET 2012	ACTUAL 2012	VARIANCE	ACTUAL 2011	INCREASE (DECREASE)
Revenue	$11,771	$11,782	$11	$11,621	$161
Expenses	11,791	11,697	94	10,765	932
Operating surplus (deficit)	$(20)	$85	$105	$856	$(771)
Less: Deficit funding	-	-	-	(527)	527
Operating surplus (deficit) excluding deficit funding	$(20)	$85	$105	$329	$(244)

2011-12 Highlights

- In 2011-12, AHS identified strategic areas that are intended to significantly improve the way health care is delivered in Alberta:
  - Be healthy, stay healthy, with a focus on reducing disparities and integrating screening infrastructure;

- Strengthen primary care: focusing on the development of the family care clinics, addiction and mental health, and community-based chronic disease management;
- Improve access and reduce wait times: wait time measurement and access to surgical capacity are priorities along with ongoing efforts to promote Tier One access measures;
- Provide more continuing care options: including home care expansion and redesign and continued implementation of the continuing care strategy;
- Build one health system: clinical workforce optimization and essential IT infrastructure.

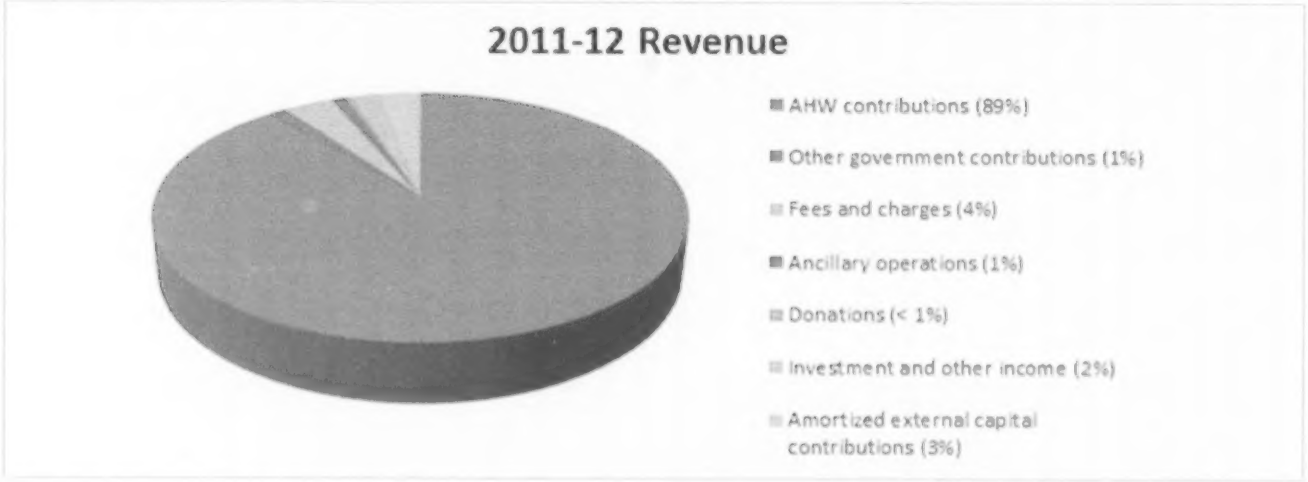
- The AHS operating surplus for the year ended March 31, 2012 is $85 compared to a budget of $(20). The $105 positive variance is primarily due to lower than budgeted expenses resulting from timing variances in both the implementation of new initiatives and recruiting physician and staff positions.
- The 2011-12 operating surplus impacted accumulated surplus and was utilized as follows:

Operating surplus	$85
Net impact of internally funded capital assets	(88)
Repayment of long term debt used to fund capital assets	(11)
Transfer of internally restricted net assets	(3)
Change in accumulated surplus	(17)
Accumulated surplus, beginning of Year	99
Accumulated surplus, end of Year	$82

- The resulting accumulated surplus for the year ended March 31, 2012 is $82. AHS annual expenditures of $11,697 equate to approximately $32 per day, hence the accumulated surplus represents approximately 2.6 days of expenses, or 0.7% of the total expense budget.

Statement of Operations

REVENUE



Total 2012 revenues increased by $161 or 1.4% from 2011 and were higher than budgeted amounts by $11. The overall increase in revenue was primarily due to increased base operating funding from AHW. AHW contributions are AHS's primary source of funding providing 89% of total revenues. AHW funding coverage indicator is 90% (2011 – 96%), representing the per cent of expenses being funded by AHW in 2012.

REVENUE	BUDGET 2012	ACTUAL 2012	VARIANCE	ACTUAL 2011	INCREASE (DECREASE)
Alberta Health & Wellness contributions	$10,452	$10,470	$18	$10,312	$158
Other government contributions	113	142	29	102	40
Fees and charges	452	416	(36)	427	(11)
Ancillary operations	117	124	7	112	12
Donations	30	40	10	29	11
Investment and other income	237	248	11	275	(27)
Amortized external capital contributions	370	342	(28)	364	(22)
Total revenue	$11,771	$11,782	$11	$11,621	$161

Significant variances are explained as follows:

- **Alberta Health & Wellness contributions** are either unrestricted or restricted in nature. Unrestricted funding is the main source of operating funding to provide health care services to the population of Alberta. Restricted funding is revenue that can only be used for specific projects and is recognized when the related expenses are incurred.

ALBERTA HEALTH & WELLNESS CONTRIBUTIONS	BUDGET 2012	ACTUAL 2012	VARIANCE	ACTUAL 2011	INCREASE (DECREASE)
Unrestricted ongoing	$9,634	$9,634	$-	$9,037	$597
Unrestricted deficit funding	-	-	-	527	(527)
Restricted	818	836	18	748	88
Total Alberta Health & Wellness contributions	$10,452	$10,470	$18	$10,312	$158

AHW contributions resulted in a positive variance of $18 or 0.2% as compared to budgeted levels due to increased grant revenue recognized primarily for the Academic Alternate Relationship Plan (AARP) and increased Primary Care Networks revenue. The overall positive variance is partially offset by lower than anticipated grant spending for Continuing Care Strategy: Aging in the Right Place and Alberta Cancer Prevention Legacy Fund, as well as timing differences related to the implementation of the Virtual Site Training Plan for the Calgary South Health Campus.

AHW contributions increased by $158 in 2012 compared to 2011 due to the increase in base operating funding of 6% or $545 as established in the Five Year Funding Commitment by Government, additional funding for the Continuing Care Strategy - Home Care Program and Air Ambulance Services amounting to $52, and an increase in revenue recognized from other restricted contributions of $88; partially offset by the fiscal 2011 one-time funding for accumulated deficit of $527, not repeated in fiscal 2012.

- **Other government contributions** is ongoing and one-time contributions for operating purposes from federal, provincial (other than AHW) and municipal governments. Other government contributions resulted in a positive variance of $29 or 26% as compared to budgeted levels mainly due to the recognition of unbudgeted funding from Advanced Education and Technology (AET) for the salary and benefits of the University of Alberta and University of Calgary faculty members jointly appointed with AHS.

The increase in other government contributions of $40 as compared to the prior year is primarily due to the additional funding from AET and revenue recognized for Midwifery and Health Workforce Action Plan grants.

- **Fees and charges** consist of patient revenue for health services at rates set by the Minister of Health and Wellness and collected by AHS and contracted long-term care providers from individuals, Workers Compensation Board (WCB), federal and provincial governments, and other responsible parties such as Alberta Blue Cross and insurance companies.

  Fees and charges revenue resulted in a negative variance of $36 or 8% as compared to budgeted levels, which is primarily due to lower than anticipated revenues from out-of-country patient billings and private and semi-private room charges, as well as an increase in bad debt expense, due mainly to a comprehensive review of patient accounts carried out in the current year.

  The decrease of $11 as compared to the prior year is mainly attributable to an increase in bad debts expense, as a result of the overall comprehensive review, partially offset by an increase in WCB revenues, out-of-province charges, and out-of-country charges.

- **Ancillary operations** include parking, non-patient food services and the sale of goods and services.

  Ancillary operations resulted in a positive variance of $7 or 6% mainly due to increased salary recoveries related to PCNs, increased food services revenue based on increased pricing in order to offset the respective costs and increased number of parking stalls resulting in increased parking revenue.

  The increase of $12 as compared to the prior year is primarily due to increased revenue from the sale of goods and services due mainly to increased salary recoveries from PCNs, increased price adjustments to offset the cost of food resulting in increased food services revenue, and increased number of stalls resulting in increased parking revenue.

- **Donations** include contributions from foundations and voluntary donations for non-capital purposes that are restricted and unrestricted. Capital contributions from foundations are reported on the Consolidated Statement of Cash Flows.

  Donations revenue resulted in a positive variance of $10 or 33% mainly due to a change in the funding process whereby the funding provided by the Stollery Children's Hospital Foundation now flows to AHS directly for the Department of Paediatrics, and the Women and Children's Health Research Institute. The increase of $11 as compared to the prior year is mainly due to the change in funding process as provided by the Stollery Children's Hospital Foundation.

- **Investment and other income** is comprised of interest income, dividends, net realized gains and losses on disposal of investment, recoveries and revenue from drug companies, medical supply companies, and universities, and other non-government grants.

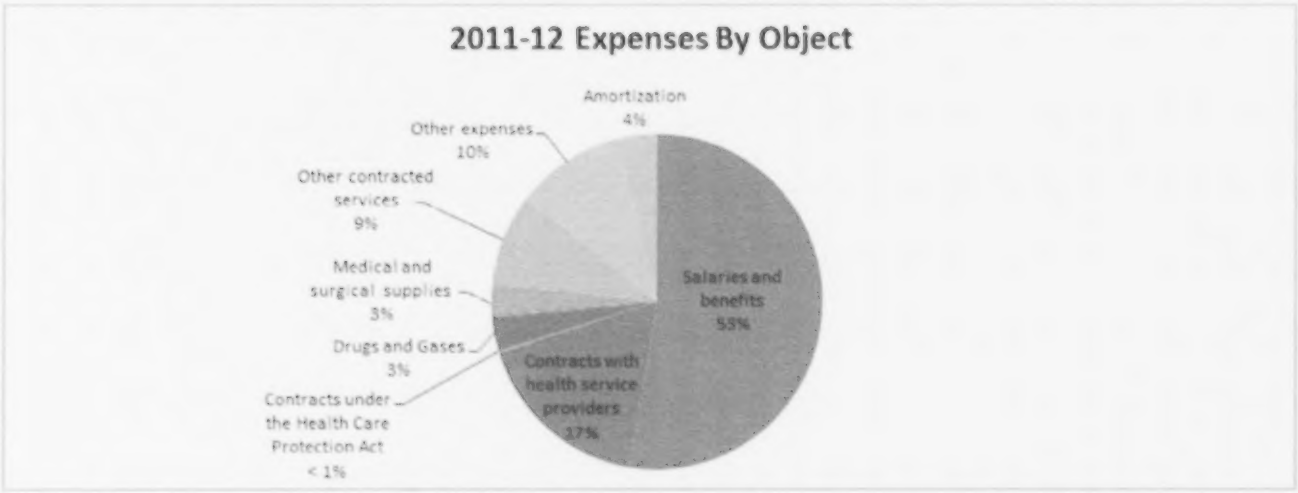
  Investment and other income resulted in a positive variance of $11 or 5% as compared to budgeted levels mainly due to higher than expected revenues from non-government operating grants, purchase incentive rebates and recoveries; partially offset by decreased investment income as a result of a decrease in the investment portfolio and higher bond premium amortization expense.

  The decrease of $27 as compared to the prior year is due to lower capital gains on investment sales, higher bond amortization expense and lower recoveries. The overall decrease is partially offset by an increase in purchase incentive rebates and non-government operating grants.

- **Amortized external capital contributions** are the restricted revenue recognized from external agencies for capital assets that are amortized during the period.

  The $28 or 8% negative variance in amortized external capital contributions is mainly due to less than anticipated spend on externally funded capital equipment and progress delays in facility upgrade initiatives resulting in amortization starting later than expected. The decrease of $22 as compared to the prior year is mainly attributed to an increase in fully amortized assets and a decrease in new externally funded asset purchases ready to be amortized.

EXPENSES – BY OBJECT


2011-12 Expenses By Object
Amortization 4%
Other expenses 10%
Other contracted services 9%
Medical and surgical supplies 3%
Drugs and Gases 3%
Contracts under the Health Care Protection Act < 1%
Contracts with health service providers 17%
Salaries and benefits 53%

The distribution of expenses by object has remained consistent with prior years, with salaries and benefits making up more than half of total expenses. While AHS continues to focus on priority areas such as reducing wait times in emergency departments, expanding continuing care operations and improving access to high-demand surgeries, expenses continue to be driven by salaries, benefits, health and other contracted services.

During 2011-12, the organization continued to experience challenges in recruiting physicians and staff at the pace anticipated within the 2011-12 operating budget, resulting in implementation delays of certain priority initiatives including Continuing Care Capacity Plan, Provincial Obesity initiative, and Alberta Colorectal Cancer initiative. The overall positive variance was partially offset by increased patient volumes and activity in certain areas resulting in increased drugs, gases, medical and surgical supplies, clinical supplies, laundry and linen costs. The addition of new sites further offset the positive variance, resulting in increased lease, occupancy and maintenance costs.

EXPENSES	BUDGET 2012	ACTUAL 2012	VARIANCE	ACTUAL 2011	INCREASE (DECREASE)
Salaries and benefits	$6,315	$6,156	$159	$5,667	$489
Contracts with health service providers	2,108	2,041	67	1,882	159
Contracts under the Health care Protection Act	19	18	1	19	(1)
Drugs and gases	362	388	(26)	362	26
Medical and surgical supplies	334	360	(26)	330	30
Other contracted services	1,065	1,038	27	974	64
Other	1,093	1,221	(128)	1,060	161
Amortization	495	475	20	471	4
Total expenses	$11,791	$11,697	$94	$10,765	$932

Significant variances and changes are explained as follows:

- **Salaries and benefits** is comprised of compensation for worked hours, vacation and sick leave, other cash benefits (which includes overtime), employee benefit contributions made on behalf of employees, and severance.

Salaries and benefits amounted to $6,156 compared to a budget of $6,315 resulting in a positive variance of $159 or 3% mainly relating to vacancies and timing of recruitment. Many of the vacant positions include positions that are difficult to recruit including pathologists, oncologists and allied health professionals. As a result of these specific and specialized requirements, slower than expected recruitment has contributed to the positive variance at year end.

There is an increase of $489 over prior year mainly due to the increased number of employees, salary rate increases and increased overtime expenses. As recruitment efforts continued throughout the year, the number of employees increased compared to the prior year. However, vacancies persisted throughout the organization, increasing capacity pressures and resulting in the need for increased overtime.

- **Contracts with health service providers** include voluntary and private health service providers with whom AHS contracts for health services.

  Contracts with health service providers amounted to $2,041 compared to a budget of $2,108 resulting in a positive variance of $67 or 3% mainly relating to timing variances associated with the implementation of various budgeted initiatives, including the Aging in the Right Place program and timing of beds opened under the Continuing Care Capacity Plan. A grant payment provided to a contracted health service provider partially offset the overall positive variance.

  There is an increase of $159 over prior year due to the addition of 1,002 continuing care beds and contract rate increases of 3.8%, partially offset by a decrease in a grant provided to a contracted health service provider.

- **Contracts under the Health Care Protection Act** relates to contracts with surgical facilities pursuant to the Health Care Protection Act which is about ensuring more efficient delivery of publically funded services by allowing contracting out to profit-orientated surgical facilities.

  Contracts under the Health Care Protection Act amounted to $18 compared to a budget of $19 resulting in a positive variance of $1 or 5%.

  There is a decrease of $1 over prior year.

- **Drugs and gases** expenses include all drugs used by AHS, including medicines, certain chemicals, anaesthetic gas, oxygen and other medical gases used for patient treatment, but exclude vaccines paid for by AHW. Drugs used for other than patient treatment are not considered to be part of this category, but rather included in other expenses.

  Drugs and gases amounted to $388 compared to a budget of $362 resulting in a negative variance of $26 or 7% due to increased activity levels, particularly as a result of patient volumes, throughout the province resulting in the increased use of drugs and gases. Further increased costs resulted from increases in cardiovascular, spine and cancer related surgeries. Deficits existed predominantly in the areas of IV solutions, anti-infective and anti-viral medication.

  There is an increase of $26 over the prior year mainly due to inflation, introduction of new drugs, aging population and increased activity, particularly in surgeries, including lung, spine and cardiovascular.

- **Medical and surgical supplies** include prostheses, instruments used in surgical procedures and in treating and examining patients, sutures and other supplies.

  Medical and surgical supplies amounted to $360 compared to a budget of $334 resulting in a negative variance of $26 or 8% mainly due to increased activity throughout inpatient, emergency, outpatient and diagnostic and therapeutic services. The increased activity resulted in increased usage of various medical and surgical supplies related to transcatheter aortic-valve implantations (TAVIs), ventricular assist devices, catheters, and supplies required for spine, trauma and emergency surgeries.

There is an increase of $30 over the prior year mainly due to the implementation of new initiatives, including an increased number of cardiac, lung and oncology procedures.

- **Other contracted services** are payments to those under contract that are not considered to be employees. This category includes fee-for-service payments to physicians, referred-out services and purchased services.

  Other contracted services amounted to $1,038 compared to a budget of $1,065 resulting in a positive variance of $27 or 3% mainly due to physician recruitment issues resulting in increased vacancies, timing of contracts and delayed implementation of initiatives (i.e. General Internal Medicine project, various initiatives funded through the Alberta Cancer Prevention Legacy Fund (ACPLF), Influenza and Blood Passages).

  There is an increase of $64 from prior year due to increased activity from the prior year, resulting in increased contracts, creation of additional medical leadership positions and increased use of contracted services in certain areas due to vacancies within the organization.

- **Other expenses** relate to those not classified elsewhere.

  Other expenses amount to $1,221 compared to a budget of $1,093 resulting in a negative variance of $128 or 12% due to an increase in the provision for unpaid claims and additional increases in surgical procedures and patient volumes resulted in increased clinical supplies, housekeeping and linen costs. Additional costs were also incurred due to increased information technology spending on the replacement of high priority clinical equipment and aging end user IT devices, and The Human Resources Management Systems (HRMS) project and the transitioning of Emergency Medical Services sites resulted in increased lease costs, occupancy costs and contract service maintenance costs. Further, facility and maintenance costs increased due to the addition of new sites across the province. The overall negative variance is partially offset by reduced activity in some multi-year initiatives, including paediatric oncology and various initiatives funded through ACPLF.

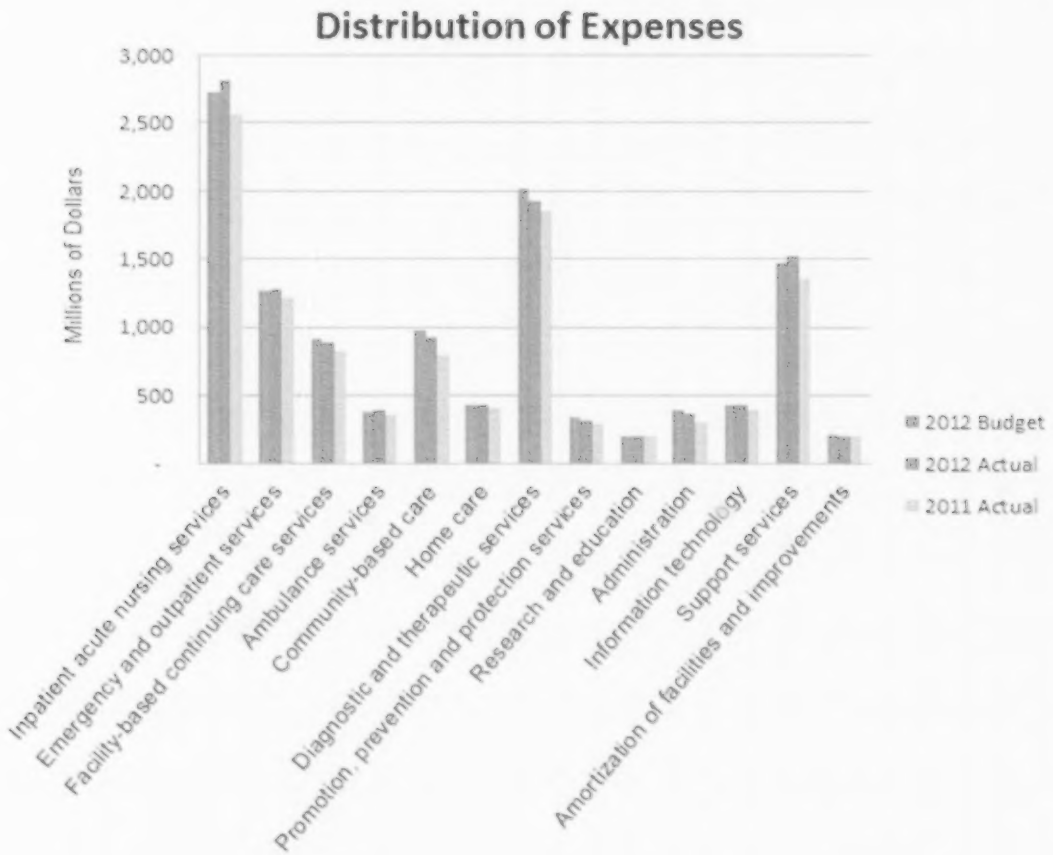
  There is an increase of $161 over the prior year mainly due to the expenses highlighted in the variance explanation above as well as inflation and patient volume increases.

- **Amortization expenses** relates to the periodic charges to expense representing the estimated portion of the cost of the respective physical asset that expired through use and age during the period.

  Amortization expenses amounted to $475 compared to a budget of $495 resulting in a positive variance of $20 or 4% mainly due to capitalization delays in facility upgrades and system initiatives.

  There is an increase of $4 over the prior year mainly relating to the annualization of amortization for Villa Caritas, and asset additions at Rockyview General Hospital and the Cochrane Health Centre, which are now being amortized.

EXPENSES – BY PROGRAM



Total expenses in 2011-12 increased by 8.7% from 2010-11 and were lower than budgeted amounts by 0.8%. The overall increase in expenses was primarily due to increased salary and benefit costs, increased contract costs, inflation and increased patient volumes. AHS's distribution of expenses has remained consistent with the previous year, with inpatient acute nursing services and diagnostic and therapeutic expenses making up over 40% of total expenses. The largest increases as compared to the prior year were seen in inpatient acute nursing services, community-based care, and support services.

EXPENSES	BUDGET 2012	ACTUAL 2012	VARIANCE	ACTUAL 2011	INCREASE (DECREASE)
Inpatient acute nursing services	$2,729	$2,812	$(83)	$2,568	$244
Emergency and other outpatient services	1,274	1,279	(5)	1,216	63
Facility-based continuing care services	914	893	21	830	63
Ambulance services	379	392	(13)	352	40
Community-based care	983	921	62	798	123
Home care	437	429	8	402	27
Diagnostic and therapeutic services	2,011	1,930	81	1,856	74
Promotion, prevention and protection services	344	311	33	289	22
Research and education	206	198	8	207	(9)
Administration	392	364	28	304	60
Information technology	429	434	(5)	388	46
Support services	1,474	1,528	(54)	1,357	171
Amortization of facilities and improvements	219	206	13	198	8
Total expenses	$11,791	$11,697	$94	$10,765	$932

Significant variances are explained as follows:

- **Inpatient acute nursing services** is comprised predominantly of nursing units, including medical, surgical, intensive care, obstetrics, paediatrics and mental health. This category also includes operating and recovery rooms.

  Inpatient acute nursing services amounted to $2,812 compared to a budget of $2,729 resulting in a negative variance of $83 or 3% mainly due to increased activity (including increased joint surgeries and intensive care medicine) and increased patient days. The increased activity has resulted in increased spending on drugs, gases, medical and surgical supplies. During the year, vacancies and recruitment timing has also resulted in increased overtime costs within salaries, as well as increasing contract costs with health service providers, including agency nurses.

  There is an increase of $244 over prior year mainly due to increased activity (including additional hospital beds and surgical cases), inflationary increases in both labour and supplies and increased overtime costs.

- **Emergency and other outpatient services** are comprised primarily of emergency, day/night care, clinics, day surgery, and contracted surgical services.

  Emergency and outpatient services amounted to $1,279 compared to a budget of $1,274 resulting in a negative variance of $5 or 0.4% mainly due to difficulties in recruiting staff, thereby creating vacancies. Maintaining service levels, as well as responding to increased activity levels in some areas have increased costs for overtime, as well as contract costs with health service providers in order to fill gaps. The overall increased activity levels have resulted in increased salary, benefits, supplies and drug costs.

  There is an increase of $63 over prior year due to inflation, growth and initiatives to reduce emergency wait times. Activity increases have been experienced in mental health initiatives, midwifery, ophthalmology, cancer, catheterization labs, renal, and cardiac specialties, including implantable cardiac devices.

- **Facility-based continuing care services** are comprised of long-term care including chronic and psychiatric care operated by AHS and contracted providers.

Facility-based continuing care services amounted to $893 compared to a budget of $914 resulting in a positive variance of $21 or 2% due mainly to delays in seniors' health initiatives resulting in decreased contract costs and vacancies resulting in decreased salaries and benefits costs.

There is an increase of $63 over the prior year due to increased activity as new care spaces opened in fiscal 2011-12, along with the annualized impact of fiscal 2010-11 care space openings. Further increased costs arose due to contract inflation and contract spending related to grant agreements and increased salaries and benefits costs related to increased activity and rates. The overall increase in capacity was partially offset by facility closures during 2011-12.

- **Ambulance services** are comprised of EMS ambulance, patient transport, and EMS central dispatch.

  Ambulance services amounted to $392 compared to a budget of $379 resulting in a negative budget variance of $13 or 3% mainly due to increased salary and benefits costs related to overtime to fill vacancies and increased other expenses related to increased spending on uniform costs and fleet maintenance as a result of increased supplier costs.

  There is an increase of $40 over prior year mainly due to contractual inflation in contracts with health service providers and other contracted services. In addition, increased costs were also incurred in contracts with health service providers and other contracted services due to the completion of the transition of air ambulance services to AHS. There were also increased out-of-province transfers, resulting in increased contract costs, as well as increased salary costs as a result of overtime.

- **Community-based care** is comprised primarily of supportive living, and palliative and hospice care. This category also consists of community programs; primary care networks (PCNs), urgent care centres, and community mental health.

  Community-based care amounted to $921 compared to a budget of $983 resulting in a positive variance of $62 or 6% mainly due to a surplus in salaries and benefits as a result of recruitment issues leading to vacancies, timing in the opening of supportive living beds within the fiscal year, as part of the Continuing Care Capacity Plan and delayed activity on multi-year grants including Safe Communities, Alberta Seniors and Technology grants resulting in decreased contract and other expenses.

  There is an increase of $123 over prior year mainly due to the opening of new supportive living spaces in fiscal 2012 and the annualized impact of fiscal 2011 openings, contract inflation increases and increased activity in various programming including Safe Communities, Children's Action Plans, Children's Mental Health Capacity Building and Life Skills Substance Abuse, resulting in an increase in salaries and benefits and contract costs. The overall increase was partially offset by the slower ramp up to the Continuing Care Capacity Plan initiatives.

- **Home care** is comprised of home nursing and support.

  Home care amounted to $429 compared to a budget of $437 resulting in a positive variance of $8 or 2% mainly due to less than budgeted salaries and benefits expense as a result of vacancies and delayed hires during the year, partially offset by an increase in contracts with health service providers as a result of increased home care hours in certain areas.

  There is an increase of $27 over prior year mainly due to increased salary and benefits costs as a result of increased activity and rate increases. The increase in home care hours also resulted in increased contract costs, further impacted by contract inflation.

- **Diagnostic and therapeutic services** is comprised primarily of clinical lab (both in the community and acute), diagnostic imaging, pharmacy, acute and therapeutic services such as physiotherapy, occupational therapy, respiratory therapy and speech language pathology.

  Diagnostic and therapeutic services amounted to $1,930 compared to a budget of $2,011 resulting in a positive variance of $81 or 4% mainly due to recruitment issues resulting in vacancies, specifically in pharmacy, therapy and laboratory services, which resulted in an overall decrease in salaries and benefits. The overall surplus was partially offset by increased costs in drugs, gases, medical and surgical supplies and other contracted services costs due to increased activity levels in several areas.

  There is an increase of $74 over prior year mainly attributable to inflation and increased activities including additional hip and knee replacement activity, oncology activity growth, increased lab tests and an increase in patient days within a couple of the larger centres. Additional activities including filling positions related to the McCaig Tower and the addition of Cochrane Health Centre also resulted in increased expenses.

- **Promotion, prevention and protection services** are comprised primarily of health promotion, disease and injury prevention, health protection, and emergency preparedness.

  Promotion, prevention and protection services amounted to $311 compared to a budget of $344 resulting in a positive variance of $33 or 10% due to recruitment issues resulting in vacancies and a more gradual start to several initiatives including Newborn Metabolic Screening, West Nile, Healthy Weights, Tobacco Reduction, Immunization, Blood Borne Pathogens and Alberta Cancer Prevention Legacy Fund initiatives. The delayed initiatives have resulted in positive variances mainly within other contracted services and salaries and benefits.

  There is an increase of $22 from prior year mainly due to increased activity levels, inflationary increases in both labour and contracts, as well as the restructuring of the information technology infrastructure within the organization.

- **Research and education** pertains to formally organized health research and graduate medical education, primarily funded by donations and third party contributions.

  Research and education amounted to $198 compared to a budget of $206 resulting in a positive variance of $8 or 4% mainly due to reduced activity in a few multi-year grants, including Community Treatment Orders, Safe Communities, Paediatric Oncology and Alberta Seniors. There were also decreased salary and benefit costs as a result of various vacant positions and delays in recruitment. The overall positive variance was partially offset by increased activity in several research initiatives backed by grant funding.

  There is a decrease of $9 from prior year mainly due to the completion of and closure of several research grants including cancer research grants and University of Alberta grants. The overall decrease was partially offset by increased salary and benefits costs associated with increased residents in fiscal 2012 and the filling of vacancies, along with increased activity in new initiatives.

- **Administration** is comprised of human resources, finance and general administration as well as a share of administration of contracted health service providers. General administration includes senior executive and many functions such as communications, planning and development, privacy, risk management, internal audit, infection control, quality assurance, insurance, patient safety, and legal. Activities and costs directly supporting clinical activities are excluded.

  Administration amounted to $364 compared to a budget of $392 resulting in a positive variance of $28 or 7% due to operational and physician recruitment delays resulting in vacancies throughout several areas of the organization decreasing salaries and benefits costs, as well as changes in the implementation project schedule for the South Health

Campus in Calgary resulting in decreased spending in the areas of salaries and benefits as compared to budget. The early termination of the outsourced payroll contract and delayed activity rounded out the overall positive variance. Additional expenses related to the provision for unpaid claims have partially offset the overall positive variance.

There is an increase of $60 from the prior year mainly due to additional expenses related to the provision for unpaid claims, increased salary and benefits costs associated with the recruitment of various staff, management and executive positions including planning positions for South Health Campus and the Alberta Improvement Way support teams, incremental increase for the HRMS project, annualizations and inflation. The overall increase was partially offset by reduced expenses from the termination of the outsourced payroll contract.

- **Information technology** is comprised of infrastructure and systems support, telecommunications, device and print services, data processing, system development and software.

  Information technology amounted to $434 compared to a budget of $429 resulting in a negative variance of $5 or 1% mainly due to the replacement of high priority technology and aging end user devices, partially offset by increased vacancies.

  There is an increase of $46 over prior year attributable to increased costs in other expenses for the replacement of high priority clinical technology and aging end user devices, and the centralization of telecommunications services and support. Further increased costs were experienced in contract costs and salaries and benefits related to contractual service and support increases and salary rate increases. The overall increase is partially offset by cost savings associated with consolidating software services and support contracts.

- **Support services** is comprised of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution and sterilization), housekeeping, laundry and linen services, patient registration, health records and food services.

  Support services amounted to $1,528 compared to a budget of $1,474 resulting in a negative variance of $54 or 4% mainly due to increased spending on minor equipment and telecommunications, particularly with respect to the replacement of high priority clinical technology within other expenses, as well as a grant provided to a contracted health service provider. These costs are partly offset by a decrease in salaries and benefits related to vacancies and various positions filled later in the year.

  There is an increase of $171 from the prior year mainly due to increased costs related to the set-up of new facilities (Mazankowski Alberta Heart Institute, South Health Campus, and Robbins Pavilion – Ortho Surgery Centre), site specific renovations, inflation, minor equipment costs, telecommunication costs, and increased activity resulting in increased salaries and benefit costs and increased contracted services costs. The overall increase was partially offset by a decrease in funding provided to a contracted health service provider related to a capital asset grant, as well as lower conversion costs related to new system implementations.

- **Amortization of facilities and improvements** is comprised of amortization of buildings, building service equipment and land improvements capitalized by AHS (exclusive of the portion of amortization charged to ancillary operations). Amortization of equipment is not disclosed separately on the statement of operations, but is instead included in each of the other expense classifications above.

  Amortization of facilities and improvements amounted to $206 compared to a budget of $219 resulting in a positive variance of $13 or 6% mainly due to delays in facility upgrade initiatives resulting in delays in the completion of capital projects.

  There is an increase of $8 over the prior year mainly due to the annualization of amortization for Villa Caritas, and asset additions at the Rockyview Hospital and the Cochrane Health Centre.

Statement of Financial Position

The following table summarizes the Consolidated Statement of Financial Position:

CONSOLIDATED STATEMENT OF FINANCIAL POSITION	2012 ACTUAL	2011 ACTUAL	INCREASE (DECREASE)	% INCREASE (DECREASE
Current assets	$2,249	$2,281	$(32)	(1.4)%
Non-current assets	7,723	7,414	309	4.2%
Total assets	$9,972	$9,695	$277	2.9%
Current liabilities	$2,116	$2,284	$(168)	(7.4)%
Non-current liabilities	6,813	6,468	345	5.3%
Net assets	1,043	943	100	10.6%
Total liabilities and net assets	$9,972	$9,695	$277	2.9%

Overall net assets for fiscal 2012 are $1,043. AHS ended the year with an accumulated surplus of $82, representing a decrease of $17 from March 31, 2011, primarily due to an operating surplus of $85, offset by a net decrease in internally funded capital assets of $88 and long-term debt repayment of $11. Furthermore, the Board has approved an $8 internal restriction related to parkades, which has been partially offset by $5 in IT purchases for South Health Campus.

Accumulated net unrealized gains on investments of $5, internally restricted net assets invested in capital assets of $876 and other internally restricted net assets of $70 rounded out the overall net assets.

WORKING CAPITAL

WORKING CAPITAL	ACTUAL 2012	ACTUAL 2011	INCREASE (DECREASE)
Total Current Assets	$2,249	$2,281	$(32)
Total Current Liabilities	$2,116	$2,284	$(168)
Working Capital Ratio	1.06	1.00	0.06

Working capital ratio is a measure of an entity's liquidity and is defined as current assets divided by current liabilities. A ratio greater than 1.0 indicates that AHS, if required, could repay all its current liabilities by liquidating its current assets. In 2011-12, the slight increase in AHS's working capital ratio was mainly due to the significant decrease in the current portion of deferred contributions and long-term debt, which strengthened the balance sheet compared to 2010-11.

A portion of current liabilities are attributable to capital expenditures which are funded by restricted funds held in non-current cash and investments and capital contributions receivable. AHS receives its monthly funding in advance on the first of the month and invests the cash to maximize investment income until required to meet its current obligations.

CASH POSITION

AHS's cash and short-term investments position is closely managed and is considered to be adequate to meet ongoing cash requirements. The Consolidated Statement of Cash Flows summarizes the sources and uses of cash in 2011-12.

CASH, CASH EQUIVALENTS AND INVESTMENTS

AHS has a responsibility to ensure that its funds are invested in a way that promotes short and long-term sustainability of the organization's operations. The overall investment strategy for AHS, including an acceptable level of risk and return is determined by the AHS Board. Investments are made in accordance with applicable legislation, AHS bylaws and policies and AHS's strategic objectives. Depending on the timing of expenditures, AHS's funds are held in cash, cash equivalents and investments. AHS's cash, cash equivalents and investments at March 31, 2012 decreased from $2,321 to $2,152 mainly due to operating and program initiatives in the year, which drew down overall balances. The balance includes $1,100 of restricted funding received by AHS, which is deferred until the relevant expenses are incurred. The remaining funds are unrestricted and used for internally funded capital expenditures and operational spending. Consistent with the decrease in overall cash, cash equivalents and investments, the investment portfolio realized a net reduction of $198 in investments due to a net redemption of $5,298 greater than purchases of $5,100 during the year.

CAPITAL ASSETS

CAPITAL ASSETS	ACTUAL 2012	ACTUAL 2011	INCREASE (DECREASE)
Cost	$11,801	$10,852	$949
Accumulated amortization	$4,586	$4,145	$441
Net book value	$7,215	$6,707	$508

The total unamortized capital assets as at March 31, 2012 consist of $124 of land and land improvements, $3,846 of facilities, $781 of equipment and building service equipment, $286 of information systems, $68 of leased facilities and improvements and $2,110 of work in progress. The work in progress consists of $881 for the South Health Campus, $411 for the University of Alberta Hospital Edmonton Clinic, $130 for the South Health Campus parkade, $72 for the Fort Saskatchewan Health Centre, $38 for the Foothills Medical Centre expansion, $35 for the Strathcona County Hospital, $28 for the Stollery Children's Hospital, $25 for the ER/Ambulatory Care Expansion, and $490 for other capital expenditures.

The estimated remaining useful life for equipment and information systems increased from 3.0 years to 3.5 years; the estimated useful life for facilities decreased from 19.6 years to 18.9 years in 2012. The capital purchases compared to the annual amortization expense indicates the rate of reinvestment; the reinvestment rate for equipment and information systems was 132% in 2012 (2011 – 146%) and for facilities was 301% in 2012 (2011 – 313%).

Equipment purchased in 2011-12 amounted to $205 and was funded 33% externally and 67% internally (2010-11 equipment purchases of $202 were funded 47% externally and 53% internally). Purchases for facilities and improvements in 2011-12 amounted to $143 and were funded 74% externally, 4% internally and 22% debt-funded (2010-11 purchases for facilities and improvements of $539 were funded 87% externally and 13% debt-funded). Information systems purchased in 2011-12 amounted to $138 and was funded 36% externally and 64% internally (2010-11 information systems purchases of $180 were funded 24% externally and 76% internally). AHS relies significantly on external sources for funding capital expenditures.

AHS has approved capital commitments of $85 for facilities and improvements, $50 for information systems and $114 for equipment.

DEFERRED CONTRIBUTIONS

Restricted contributions are a key source of revenue for AHS. Through these funds, AHS is able to implement various operating and capital initiatives intended to improve the quality of health care in Alberta. Restricted contributions are subject to timing and purpose restrictions imposed by funding agencies, which are deferred and recognized as revenue in the year the related expenses are incurred. During the year, AHS received or accrued $870 in restricted funding, spent $1,039 in related expenses, received $4 in restricted investment income, and transferred in $7 from deferred capital contributions, resulting in an overall decrease in deferred contributions of $158.

DEFERRED CAPITAL CONTRIBUTIONS

Consistent with deferred contributions, deferred capital contributions also represents grant funding subject to timing and restrictions imposed by funding agencies, particularly for capital spending. During the year, AHS received or accrued $144 in restricted grant funding, spent $224 in related expenditures, received $2 in restricted investment income, transferred $7 to deferred contributions, and returned $97 net surplus funds to the respective funding organizations - resulting in an overall decrease in deferred capital contributions from $542 to $360.

During the year, AHS also received $495 in capital assets from AI, which were subsequently transferred to unamortized external capital contributions.

LONG-TERM DEBT

AHS manages the borrowing required for large-scale capital projects through the negotiation of borrowing rates, terms and conditions, managing repayments, as well as performing cost-benefit analysis relating to current and potential borrowings. All borrowing must be made in accordance with AHS's borrowing bylaw and requires approval by the AHS Board. AHS's long-term debt is mainly comprised of debentures issued to Alberta Capital Financing Authority to finance the construction of parkades. The overall increase in long-term debt is mainly attributable to new borrowings on parkade construction, offset by principal repayments. During the year, there were $194,000 in debt proceeds received, offset by $160,320 in principal and term loan repayments.

Financial Reporting, Control and Accountability

FINANCIAL REPORTING

2011-12 was the third year for AHS as an entity.

AHS was established under the Regional Health Authorities Act (Alberta). Effective April 1, 2009, the name of East Central Health was amended to Alberta Health Services (AHS). All other Regional Health Authorities, the Alberta Mental Health Board, the Alberta Cancer Board and the Alberta Alcohol and Drug Abuse Commission were disestablished and amalgamated with AHS. All assets, liabilities, rights and obligations of the disestablished entities were assumed by AHS.

The AHS consolidated financial statements have been prepared in accordance with Canadian generally accepted accounting principles and the reporting requirements of Alberta Health and Wellness Financial Directive 5. The chart of accounts that AHS uses to report expenses by program and by object is based on the national standard of the Canadian Institute of Health Information (CIHI). Detailed site based results are submitted to CIHI annually for analysis on Canada's health system and the health of Canadians.AHS quarterly and annual financial reports are available at www.albertahealthservices.ca under publications.

The Auditor General is the appointed auditor of AHS. In addition to expressing an audit opinion on the AHS annual consolidated financial statements, the Auditor General also reports to the legislature significant recommendations related to AHS along with other government entities. The Auditor General's reports are available at www.oag.ab.ca under public reports.

FINANCIAL CONTROL AND ACCOUNTABILITY

An effective integrated governance model is an essential component in support of improving:

- The delivery of care and services;
- Support for people who deliver care and services; and
- The way the organization operates.

The Board of Directors (the 'Board') provides oversight and carries out its risk management mandate primarily through its Board Committees which include: Audit and Finance Committee, Quality & Safety Committee, Governance Committee, Health Advisory Committee, and Human Resources Committee.

The Audit and Finance Committee has responsibility for overseeing the financial control and accountability systems of AHS. AHS has established an internal audit function with the mandate of providing independent assurance to management and the Board on AHS operations. The scope of Internal Audit's work is to determine whether AHS's risk management, control and governance processes are adequate and functioning effectively. The Chief Audit Executive is also responsible for coordinating AHS's Enterprise Risk Management policy and processes for identifying, monitoring and reporting risks within the organization.

Additionally, AHS has recently formed the Internal Controls over Financial Reporting (ICOFR) function which is tasked with ensuring that the financial reporting environment mitigates the risk of material misstatements by establishing a sustainable framework of internal controls over financial reporting. In fulfilling its mandate, ICOFR will ensure that appropriate internal controls are designed, implemented and documented within AHS. Currently, the ICOFR team is working on the documentation of transaction level controls.

CHANGE IN ACCOUNTING FRAMEWORK IN FISCAL 2012-13

The Public Sector Accounting Board of the CICA (PSAB) issued a framework for financial reporting by government not-for-profit organizations (GNFPOs). As provided by the Public Sector Accounting Standards (PSAS), AHS as a GNFPO had the following options regarding the choice of accounting framework to adopt:

- to adopt the current public sector accounting standards used in Alberta (the same as what Alberta Health and Wellness is currently using) or
- to continue using the former not-for-profit accounting standards with some modifications (very similar to what AHS has been using in the past).

AHS was directed by Alberta Health and Wellness (AHW) to adopt the first option. AHS will adopt this framework effective April 1, 2012 and therefore the Consolidated Financial Statements for the periods ended June 30, 2012 and thereafter, will be under the new framework.

The five-year funding commitment with AHW has not taken into consideration this change in accounting framework. The impact estimated at this time for the change in accounting framework may create a projected accumulated deficit at March 31, 2015. This possibility has been discussed with AHW and will be monitored as the impacts of the change in accounting framework are finalized and as future financial results are realized.

AHS has developed a PSAS transition plan and has identified the following key differences and issues in the standards that will impact the financial statements:

- Sick leave obligations – Under the Public Sector Accounting Standards (PSAS) will be required to record accumulating non-vesting sick leave obligations. AHS will record this adjustment retroactively with restatement to relevant prior years.
- Controlled foundations – Under PSAS, AHS will be required to consolidate its controlled foundations currently disclosed in Note 21 (c) (i). AHS will record this adjustment retroactively with restatement to relevant prior years.

AHS continues to engage and work with AHW, Treasury Board and the external auditors to implement the PSAS transition plan.

AHS has also determined that following exemptions and exceptions will be applied on the first time adoption of the PSA standards as permitted by section PS 2125 of the Standards:

Exception: In applying the exception under PSAS section 2125, AHS is not allowed to revisit any accounting estimates previously made based on current information; unless there is objective evidence to support that the estimates made in the past were erroneous. There is no evidence to suggest that any significant prior estimates were made in error. This exception therefore has no impact to AHS.

Exemptions: PSAS Section 2125 permits first time adopters to elect certain exemptions. AHS has elected to use the following exemptions:

(a) Retirement and post-employment benefits

Based on PSAS, a government organization amortizes actuarial gains and losses to the liability or asset, and the related expense in a systematic and rational manner over the expected average remaining service life of the related employee group. Retroactive application of this approach requires a government organization to split the cumulative actuarial gains and losses from the inception of the plan until the date of transition to PSA Standards into a recognized portion and an unrecognized portion. However, a first-time adopter may elect to recognize all cumulative actuarial gains and losses at the date of transition to PSAS directly in accumulated surplus/deficit.

AHS has elected to use this exemption and will therefore recognize all cumulative unrecognized actuarial gains and losses as of April 1, 2011 in accumulated surplus/deficit. Thereafter, actuarial gains and losses that arise will be accounted for in accordance with PSAS where AHS will amortize actuarial gains and losses to the liability or asset over the average remaining service life of the related employee group.

(b) Business combinations

PSAS, require the purchase method to be applied to all business combinations. While the purchase method has been used previously, the details of the purchase method may vary with the accounting framework change. AHS has elected to adopt this exemption. Any item recognized under the previous financial reporting standards that does not qualify for recognition as an asset or liability under PSAS will be excluded from the opening statement of financial position.

(c) Tangible capital asset impairment

PSAS prescribes the conditions when a write-down of a tangible capital asset should be accounted for. A first-time adopter need not comply with those requirements for write-downs of tangible capital assets that were incurred prior to the date of transition (April 1, 2011) to PSAS. If a first time adopter uses this exemption, the conditions for a write-down of a tangible capital asset in PSAS are applied on a prospective basis from the date of transition. AHS has elected to use this exemption.

FORWARD-LOOKING STATEMENT DISCLOSURE

This FSD&A includes forward-looking statements and information about the organization's outlook, direction, operations and future financial results that are subject to risks, uncertainties and assumptions. As a consequence, actual results in the future may differ materially from any conclusion, forecast or projection in such forward-looking statements. Therefore, forward-looking statements should be considered carefully and undue reliance should not be placed on them.

OUTLOOK

Fiscal 2012-13 will mark the third year of the provincial government's five-year funding commitment. This funding commitment will enable AHS to stabilize and strengthen its operations, workforce, and allow continued planning over a medium term horizon.

Three Year Outlook

The three year outlook, which excludes the consideration of the change in accounting framework, assumes that AHS will end the five-year funding commitment at March 31, 2015 in a balanced position. In addition, under the terms of the five-year funding commitment between Government and AHS, the increase in annual base operating funding changes from six percent (2010/11 through 2012/13) to four and one-half percent (2013/14 and 2014/15). As such, it is critical for AHS to plan for sustainability in the coming years.

The following assumptions were used in the development of the three year outlook:

- Consistent with the five-year funding commitment, a six per cent base operating funding increase for 2012-13 and a four and one half per cent increase for 2013-14 and 2014-15;
- Operating costs associated with the opening of Calgary South Health Campus and University of Alberta Hospital Edmonton Clinic are included based on the projected opening dates;
- The continuing care capacity plan assumes an additional 3,000 beds will be opened between 2012-13 and 2014-15;
- Contract inflation increases have been estimated and salary and benefit provisions are projected based on anticipated union agreements where available;

- Provisions have been made for new investments in the five strategy areas as identified in the Health Plan;
- A minimum of one per cent of savings is assumed per year for reinvestment and reallocation.

Sustainability

Both human resource and financial resource requirements for the future necessitate a focus on sustainability for the coming three years and beyond. The focus on sustainability is integrally linked with the other two AHS goals of quality and access.

Planning is currently underway for priority sustainability initiatives in the coming year. These initiatives will reflect the short, medium and long-term requirements for AHS. For example, in the short-term, sustainability initiatives will build on existing initiatives currently underway such as Workforce Optimization to ensure limited human resources are used efficiently, to identify opportunities for productivity improvements, ensure appropriate mix of providers and support providers to work to full scope of practice, and to support administrative and contracting efficiencies.

In the short to medium term, opportunities to ensure appropriate, effective and high quality services will be considered, building on the work that is currently being done by Strategic Clinical Networks.

In the long-term, initiatives to promote population health and wellness will be an important component of sustainability.

Overall, AHS continues to strive to improve the health status of Albertans by providing a patient-focused, quality health system that is accessible and sustainable.

Alberta Health Services

Consolidated Financial Statements

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2012

Alberta Health Services

Management's Responsibility for Financial Reporting

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Schedule 1 – Consolidated Schedule of Expenses by Object

Schedule 2 – Consolidated Schedule of Salaries and Benefits

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Schedule 4 – Consolidated Schedule of Restatements

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2012

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

MARCH 31, 2012

The accompanying consolidated financial statements for the year ended March 31, 2012 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles and the financial directives issued by Alberta Health and Wellness, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit and Finance Committee. This Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[Original signed by]

Dr. Chris Eagle
President and Chief Executive Officer
Alberta Health Services

[Original signed by]

Deborah Rhodes, C.A.
Senior Vice President Finance
Alberta Health Services

[Original signed by]

Allaudin Merali, C.A.
Executive Vice President and Chief Financial Officer
Alberta Health Services

June 7, 2012

AUDITOR GENERAL *Alberta*

Independent Auditor's Report

To the Members of the Alberta Health Services Board and the Minister of Health

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2012 and the consolidated statements of operations, changes in net assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian generally accepted accounting principles, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2012 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher, FCA]

Auditor General

June 7, 2012

Edmonton, Alberta

Alberta Health Services

CONSOLIDATED STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2012

	2012		2011
	Budget (Note 4) (Schedule 3)	Actual	Actual Restated (Note 3) (Schedule 4)
Revenue:			
Alberta Health and Wellness contributions			
Unrestricted ongoing	$ 9,634,000	$ 9,634,221	$ 9,036,852
Unrestricted deficit funding (Note 5)	-	-	527,235
Restricted	818,000	835,412	747,830
Other government contributions	113,000	141,391	101,805
Fees and charges	452,000	416,385	427,058
Ancillary operations	117,000	124,213	112,367
Donations	30,000	39,535	28,574
Investment and other income (Note 6)	237,000	248,299	275,209
Amortized external capital contributions (Note 15)	370,000	342,305	364,181
TOTAL REVENUE	11,771,000	11,781,761	11,621,111
Expenses:			
Inpatient acute nursing services	2,729,000	2,812,157	2,567,686
Emergency and other outpatient services	1,274,000	1,279,016	1,216,408
Facility-based continuing care services	914,000	893,482	829,568
Ambulance services	379,000	391,674	352,407
Community-based care	983,000	920,594	797,765
Home care	437,000	428,814	402,148
Diagnostic and therapeutic services	2,011,000	1,930,120	1,855,524
Promotion, prevention and protection services	344,000	310,914	289,313
Research and education	206,000	198,035	207,023
Administration (Note 7)	392,000	363,921	304,225
Information technology	429,000	434,442	387,648
Support services	1,474,000	1,528,142	1,357,003
Amortization of facilities and improvements	219,000	205,859	198,238
TOTAL EXPENSES (Schedule 1)	11,791,000	11,697,170	10,764,956
Operating surplus (deficiency) of revenue over expenses	$ (20,000)	$ 84,591	$ 856,155

The accompanying notes and schedules are part of these consolidated financial statements.

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2012
(thousands of dollars)

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2012

	2012 Actual	2011 Actual Restated (Note 3) (Schedule 4)
ASSETS		
Current:		
Cash and cash equivalents (Note 9)	$ 558,700	$ 764,143
Investments (Note 9)	1,217,043	957,322
Accounts receivable	238,757	201,293
Contributions receivable from Alberta Health and Wellness	78,253	200,313
Inventories	96,740	99,097
Prepaid expenses	59,100	58,946
	2,248,593	2,281,114
Non-current cash and investments (Note 9)	376,505	599,335
Capital contributions receivable from Alberta Health and Wellness	2,293	11,476
Capital assets (Note 10)	7,215,171	6,707,464
Other assets (Note 11)	129,493	96,104
TOTAL ASSETS	$ 9,972,055	$ 9,695,493
LIABILITIES AND NET ASSETS		
Current:		
Accounts payable and accrued liabilities	$ 1,198,261	$ 1,136,937
Accrued vacation pay	428,146	385,525
Deferred contributions (Note 12)	450,360	607,621
Current portion of long-term debt (Note 14)	38,802	153,799
	2,115,569	2,283,882
Deferred capital contributions (Note 13)	359,918	541,856
Long-term debt (Note 14)	331,177	182,500
Unamortized external capital contributions (Note 15)	5,974,714	5,598,973
Other liabilities (Note 16)	147,719	144,540
	8,929,097	8,751,751
Net assets:		
Accumulated surplus	81,982	98,909
Accumulated net unrealized gains (losses) on investments	4,916	(9,110)
Other internally restricted net assets (Note 17)	69,538	66,722
Internally restricted net assets invested in capital assets	876,372	777,071
Endowments (Note 18)	10,150	10,150
	1,042,958	943,742
TOTAL LIABILITIES AND NET ASSETS	$ 9,972,055	$ 9,695,493

Commitments and contingencies (Note 20)

The accompanying notes and schedules are part of these consolidated financial statements.

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2012
(thousands of dollars)

CONSOLIDATED STATEMENT OF CHANGES IN NET ASSETS
FOR THE YEAR ENDED MARCH 31, 2012

	2012						2011
	Accumulated surplus (deficit)	Accumulated net unrealized gains/ (losses) on investments	Other internally restricted net assets (Note 17)	Internally restricted net assets invested in capital assets	Endowments (Note 18)	Total	Total Restated (Note 3)
Balance at beginning of year (restated)	$ 98,909	$ (9,110)	$ 66,722	$ 777,071	$ 10,150	$ 943,742	$ 111,440
Operating surplus (deficiency) of revenue over expenses	84,591	-	-	-	-	84,591	856,155
Capital assets purchased with internal funds	(219,655)	-	-	219,655	-	-	-
Land purchased with external funds	-	-	-	599	-	599	2,500
Amortization of internally funded capital assets	132,059	-	-	(132,059)	-	-	-
Repayment of long-term debt used to fund capital assets	(10,655)	-	-	10,655	-	-	-
Net repayment of life lease deposits	(451)	-	-	451	-	-	-
Transfer of other internally restricted net assets	(2,816)	-	2,816	-	-	-	-
Net unrealized gains (losses) arising during the period on available for sale financial assets	-	22,781	-	-	-	22,781	(5,074)
Transfer of net realized losses (gains) on investments to revenue	-	(8,755)	-	-	-	(8,755)	(21,279)
Balance at end of year	$ 81,982	$ 4,916	$ 69,538	$ 876,372	$ 10,150	$ 1,042,958	$ 943,742

The accompanying notes and schedules are part of these consolidated financial statements.

Alberta Health Services

CONSOLIDATED STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2012

	2012		2011
	Budget (Note 4)	Actual	Actual Restated (Note 3) (Schedule 4)
Operating activities:			
Operating surplus (deficiency) of revenue over expenses	$ (20,000)	$ 84,591	$ 856,155
Non-cash transactions:			
Amortization expense (Schedule 1)	495,000	474,513	470,511
Amortized external capital contributions	(370,000)	(342,550)	(364,606)
Other	16,000	(14,947)	47,505
Changes in non-cash working capital (Note 19)	(53,000)	(245,106)	(737,874)
Cash generated from (used by) operating activities	68,000	(43,499)	271,691
Investing activities:			
Purchase of capital assets:			
Internally funded equipment	(65,000)	(137,402)	(107,612)
Internally funded information systems	(135,000)	(88,337)	(137,082)
Internally funded facilities and improvements	-	(5,695)	-
Externally funded equipment	(220,000)	(67,988)	(94,365)
Externally funded information systems	(70,000)	(49,907)	(43,331)
Externally funded facilities and improvements	(60,000)	(105,667)	(467,154)
Debt funded facilities and improvements	(62,000)	(31,921)	(71,353)
Purchase of investments	(5,365,000)	(5,099,643)	(7,343,537)
Proceeds on sale of investments	5,229,000	5,297,831	5,995,607
Allocations from non-current cash and investments	658,000	38,668	1,721,856
Changes in non-cash working capital (Note 19)	378,000	18,868	76,458
Cash generated from (used by) investing activities	288,000	(231,193)	(470,513)
Financing activities:			
Capital contributions received	107,000	171,082	202,923
Capital contributions returned	-	(15,759)	(58,850)
Capital contributions payable transferred to accounts payable	-	(119,754)	-
Proceeds from long-term debt	240,000	194,000	73,160
Principal payments on long-term debt	(209,000)	(160,320)	(12,565)
Cash generated from financing activities	138,000	69,249	204,668
Net increase (decrease) in current cash and cash equivalents	494,000	(205,443)	5,846
Current cash and cash equivalents, beginning of year	1,721,000	764,143	758,297
Current cash and cash equivalents, end of year	$ 2,215,000	$ 558,700	$ 764,143

The accompanying notes and schedules are part of these consolidated financial statements.

Alberta Health Services

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS MARCH 31, 2012

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta). Effective April 1, 2009, the name of East Central Health was amended to Alberta Health Services. All other Regional Health Authorities, the Alberta Mental Health Board, the Alberta Cancer Board and the Alberta Alcohol and Drug Abuse Commission were disestablished and amalgamated with AHS. All assets, liabilities, rights and obligations of the disestablished entities were assumed by AHS.

Pursuant to the *Regional Health Authorities Act* (Alberta), AHS is responsible in Alberta to:

- promote and protect the health of the population and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the population;
- determine priorities in the provision of health services and allocate resources accordingly;
- ensure reasonable access to quality health services; and
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities.

Additionally, the Mandate and Roles Document, developed by both Alberta Health and Wellness (AHW) and AHS to define the roles, responsibilities and accountabilities of each entity, identifies that AHS is accountable to the Minister of Health and Wellness (the Minister) for the delivery and operation of the public health system while AHW is mandated to support the Minister by providing direction to AHS, and in establishing AHS performance measures and targets and measuring AHS's performance.

The AHS consolidated financial statements include the revenues and expenses associated with AHS responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care. For example the Department of Health and Wellness is responsible for paying most physician fees. The Ministry of Health and Wellness consolidated financial statements contain a more complete view of the cost of the provincial health care system. For a complete picture of the costs of provincial healthcare readers should consult the Province of Alberta consolidated financial statements.

AHS's operations include the facilities and sites listed in the AHS annual report. AHS is a registered charity under the *Income Tax Act* (Canada) and is exempt from the payment of income tax.

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2012
(thousands of dollars)

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

The consolidated financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the reporting requirements of AHW in Financial Directive 5.

(i) These financial statements have been prepared on a consolidated basis. Included in these consolidated financial statements are the following wholly owned subsidiaries:

- Calgary Laboratory Services Ltd. (CLS), who provides medical diagnostic services in Calgary and southern Alberta.
- Capital Care Group Inc. (CCGI), who manages continuing care programs and facilities in the Edmonton area.
- Carewest, who manages continuing care programs and facilities in the Calgary area.

The transactions between AHS and these subsidiaries have been eliminated on consolidation. These entities of AHS are exempt from the payment of income tax.

(ii) AHS uses the proportionate consolidation method to account for its 50% interest in the Northern Alberta Clinical Trials Centre joint venture with the University of Alberta, and its 50% interest in the Primary Care Networks disclosed in Note 21(b).

(iii) AHS consolidates its interest in the Provincial Health Authorities of Alberta Liability and Property Insurance Plan (the LPIP). AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of the LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber. The LPIP is exempt from the payment of income tax but is subject to the Alberta provincial premium tax.

(iv) These consolidated financial statements do not include the assets, liabilities and operations of controlled foundations (Note 21(c)), voluntary or private contracted health service providers in the Province (Note 21(d)), or the Health Benefit Trust of Alberta (Note 21(e)). These consolidated financial statements do not include trust funds administered on behalf of others (Note 22).

(b) Revenue Recognition

These consolidated financial statements have been prepared using the deferral method of accounting for contributions; the key elements of AHS's revenue recognition policies are:

(i) Unrestricted contributions are recognized as revenue in the year received or receivable if the amount to be received is reasonably estimated and collection is reasonable assured.

(ii) Externally restricted non-capital contributions are deferred and recognized as revenue in the year the related expenses are incurred.

(iii) Externally restricted capital contributions are recorded as deferred capital contributions until invested in capital assets. Amounts expended, representing externally funded capital assets, are then transferred to unamortized external capital contributions. Unamortized external capital contributions are recognized as revenue in the year the related amortization expense of the funded capital asset is recorded.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iv) Contributions receivable from AHW and capital contributions receivable from AHW are recorded as receivable when the grant agreement has been fully executed.

(v) Pledges receivable from foundations are recorded as receivable when amounts to be received can be reasonably estimated and ultimate collection is reasonably assured.

(vi) Externally restricted contributions to purchase capital assets that will not be amortized and endowments are treated as direct increases to net assets.

(vii) Investment income includes dividend and interest income, and realized gains or losses on the sale of investments. Unrealized gains and losses on available for sale investments are included directly in net assets or deferred contributions as appropriate, until the related investments are sold. Unrealized gains and losses on held for trading investments are included in the Consolidated Statement of Operations. Restricted investment income is recognized as revenue in the year in which the related expenses are incurred. Other unrestricted investment income is recognized as revenue when earned.

(viii) In kind contributions of services and materials are recorded at fair value when such value can reasonably be determined. While volunteers contribute a significant amount of time each year to assist AHS the value of their services are not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

(ix) Revenue from sales of goods and services is recorded in the period that goods are delivered or services are provided, and are presented net of bad debt expense.

(c) Cash, Cash Equivalents and Investments

Cash and cash equivalents consist of cash on hand, balances with banks and investments in money market securities with maturities of less than three months.

Current investments consist of money market securities with original maturities of greater than three months and fixed income securities to be used in funding AHS's operations in the upcoming fiscal year.

Cash, cash equivalents and current investments are comprised of both unrestricted and restricted funds. Unrestricted funds are used for general operating purposes or internally funded capital projects.

Restricted funds consist of received but unspent deferred contributions, deferred capital contributions, amounts restricted to fund long-term insurance obligations (Note 9(d)) and other liabilities.

Non-current cash and investments consist of cash and investments in fixed income securities and equities. All non-current investments are restricted and are mainly comprised of received but unspent non-current deferred contributions and deferred capital contributions.

Alberta Health Services

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Investments are accounted for in accordance with the accounting policies described in Note 2(e). Transaction costs associated with the acquisition and disposal of available for sale investments are capitalized and are included in the acquisition costs or reduce proceeds on disposal. Investment management fees are expensed as incurred. The purchase and sale of investments are accounted for using trade-date accounting.

(d) Inventories

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and current replacement value. All other inventories are valued at lower of cost (defined as moving average cost) and net realizable value.

(e) Financial Instruments

AHS has classified its financial assets and financial liabilities as follows:

Financial Assets and Liabilities	Classification	Subsequent Measurement and Recognition
Cash and cash equivalents	Held for trading	Measured at fair value with changes in fair value recognized in the Consolidated Statement of Operations.
Investments	Available for sale	Measured at fair value with changes in fair value recognized in the Consolidated Statement of Changes in Net Assets or deferred contributions until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
	Held for trading	Measured at fair value with changes in fair value recognized in the Consolidated Statement of Operations.
Accounts receivable, contributions and capital contributions receivable from AHW	Loans and receivables	After initial fair value measurement, measured at amortized cost using the effective interest rate method.
Accounts payable and accrued liabilities, long-term debt, provision for unpaid claims and life lease deposits	Other financial liabilities	After initial fair value measurement, measured at amortized cost using the effective interest rate method.

AHS does not use hedge accounting and is not impacted by the requirements of Canadian Institute of Chartered Accountants (CICA) accounting standard Section 3865 - Hedges. AHS, as a not-for-profit organization, elected to not apply the standards for embedded derivatives in non-financial contracts. In addition, AHS has elected not to adopt Section 3862 Financial Instruments - Disclosures and Section 3863 Financial Instruments - Presentation, and instead has continued to disclose financial instruments under Section 3861 – Financial Instruments Disclosure and Presentation.

Alberta Health Services

Note 2 Significant Accounting Policies and Reporting Practices (continued)

When it is determined that an impairment of a financial instrument classified as available for sale is other than temporary, the cumulative loss that had been recognized directly in net assets or deferred contributions is removed and recognized in the Consolidated Statement of Operations even though the financial asset has not been derecognized. Impairment losses recognized in the Consolidated Statement of Operations for a financial instrument classified as available for sale are not reversed.

The carrying value of current cash and cash equivalents, accounts receivable, contributions and capital contributions receivable from AHW, accounts payable and accrued liabilities approximate their fair value because of the short term nature of these items. Unless otherwise noted, it is management's opinion that AHS is not exposed to significant interest, currency or credit risks arising from its financial instruments.

Additional disclosure on financial instruments is provided in Note 9 Cash, Cash Equivalents and Investments, Note 14 Long-term Debt and Note 16 Other Liabilities.

(f) Capital Assets

Capital assets and work in progress are recorded at cost. Capital assets and work in progress acquired from other Alberta government organizations are recorded at the carrying value of that government organization. Costs incurred by Alberta Infrastructure (AI) to build capital assets on behalf of AHS are recorded by AHS as work in progress and unamortized external capital contributions as AI incurs costs. Contributed capital assets from non-Alberta government organizations are recorded at fair value at the date of contribution.

The threshold for capitalizing new systems development is $250 and major enhancements is $100. The threshold for all other capital assets is $5. All land is capitalized.

Capital assets are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	2-20 years
Information systems	3-5 years
Building service equipment	5-40 years
Leased facilities and improvements	term of lease
Land improvements	5-40 years

Work in progress, which includes facilities and improvements projects and development of information systems, is not amortized until after a project is complete. Leases transferring substantially all benefits and risks of capital asset ownership are reported as capital asset acquisitions financed by long-term obligations.

(g) Asset Retirement Obligations

AHS recognizes the fair value of a future asset retirement obligation as a liability in the period in which it incurs a legal obligation associated with the retirement of tangible long-lived assets that results from the acquisition, construction, development, and/or normal use of the respective assets. AHS concurrently recognizes a corresponding increase in the carrying amount of the related long-lived asset that is amortized over the life of the asset. The fair value of the asset retirement obligation is estimated using the expected cash flow approach that reflects a range of possible outcomes discounted at a credit-adjusted risk-free interest rate.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Subsequent to the initial measurement, the asset retirement obligation is adjusted at the end of each period to reflect the passage of time and changes in the estimated future cash flows underlying the obligation. Changes in the obligation due to the passage of time are recognized as an operating expense using the effective interest method. Changes in the obligation due to changes in estimated cash flows are recognized as an adjustment of the carrying amount of the related long-lived asset that is amortized over the remaining life of the asset.

An asset retirement obligation related to the removal of hazardous material that would be required as part of a capital project is only recognized when there is approval from the Minister of Health and Wellness to proceed with the project.

(h) Employee Future Benefits

Registered Defined Benefit Pension Plans

AHS participates in the following registered defined benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employees Pension Plan (MEPP). These multi-employer public sector defined benefit plans provide pensions for participants, based on years of service and final average earnings. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). The Minister of Finance is the legal trustee and administrator of the plans. The Department of Finance accounts for the liabilities for pension obligations as a participating employer for former and current employees in the LAPP and the MEPP for all of the organizations included in the Government of Alberta (GOA) consolidated reporting entity except for government business enterprises. As AHS is included in the GOA consolidated reporting entity AHS follows the standards for defined contribution accounting for these pension plans. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year.

Supplemental Executive Retirement Plans (SERPs)

AHS sponsors three defined benefit SERPs which are funded. These plans cover certain employees and supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). Each plan was closed to new entrants effective April 1, 2009. A majority of the SERPs are final average plans; however, certain participant groups have their benefits determined on a career average basis. Also, some participant groups receive post-retirement indexing similar to the benefits provided under the registered defined benefit pension plans; while others receive non-indexed benefits. The obligations and costs of these benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service and management's best estimate assumptions, including a market-related discount rate.

Due to *Income Tax Act* (Canada) requirements, the SERPs are subject to the Retirement Compensation Arrangement (RCA) rules; therefore approximately half the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERPs are invested in a fixed income portfolio. The net benefit cost of SERPs reported in these consolidated financial statements include the current service cost, interest cost on the current service cost and obligations, as well as the amortization of past service cost, initial obligations and net actuarial gains and losses. These amounts are offset by the expected return on the plans' assets.

Alberta Health Services

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Past service costs, including the initial obligations of the plans, are amortized on a straight-line basis over the average remaining service lifetime of the relevant employee group. Cumulative net actuarial gains or losses over 10 percent of the greater of the benefit obligation and fair value of the plans' assets are amortized on a straight-line basis over the average remaining service lifetime of the employee group. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net benefit cost in the following year.

In the case of a curtailment event which results in the elimination for a significant number of active employees of the right to earn defined benefits for their future services, a curtailment gain or loss is recorded. A curtailment loss is recognized in income when it is probable that a curtailment will occur and the net effects are reasonably estimable. A curtailment gain is recognized in income when the event giving rise to a curtailment has occurred.

Supplemental Pension Plan (SPP)

Subsequent to April 1, 2009, staff who would have been eligible for SERP, are enrolled in a defined contribution SPP. Similar to the SERP, the SPP supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a certain percentage of an eligible employee's pensionable earnings, excluding pay at risk, in excess of the limits of the *Income Tax Act* (Canada). This plan provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings.

Other Benefits

AHS provides its employees with basic life, accidental death and dismemberment, short term disability, long term disability, extended health, dental and vision benefits through benefits carriers. AHS's contributions are expensed to the extent that they do not relate to discretionary reserves. AHS also provides its employees with sick leave benefits. AHS records non-vesting sick leave as an expense when the benefit is taken by the employee.

(i) Long-term Care Partnerships

Funding paid or payable related to long-term care partnership agreements is recognized as an expense in the period the transfer is authorized and all eligibility criteria have been met by the providers. AHS recognizes the expense in facility-based continuing care services on the Consolidated Statement of Operations and, if externally funded, an equal amount of revenue as other government contributions from deferred contributions long-term care partnership projects. The undisbursed amount, which represents the present value of future cashflows is recorded as other liabilities (Note 16(b)). Investment income earned on funding received, net of management fees, is recorded as an increase to both the investment base and the deferred contribution.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(j) Internally Restricted Net Assets Invested in Capital Assets

AHS discloses internally restricted net assets invested in capital assets separately on the Consolidated Statement of Financial Position and Consolidated Statement of Changes in Net Assets. The AHS Board has approved the restriction of net assets equal to the net book value of internally funded capital assets.

(k) Grants for Research and Other Initiatives

AHS awards grants to other organizations for research and other initiatives. The terms of the grants range from less than one year to more than one year. AHS records the committed value of the grant awarded as an expense when it has been approved and when the agreement between AHS and the principal investigator has been executed.

(l) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a significant variance between the recognized or disclosed amount and another reasonably possible amount. The amounts recorded for amortization of capital assets and amortization of external capital contributions are based on the estimated useful life of the related assets. The amounts recorded for asset retirement and employee future benefits obligations are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

(m) Capital Disclosure

For operating purposes, AHS defines capital as including working capital and unrestricted net assets. For capital purposes, AHS defines capital as including deferred capital contributions, long term debt, unamortized external capital contributions, and internally restricted net assets invested in capital assets.

AHS's objectives for managing capital are:

- In the short term, to safeguard its financial ability to continue to deliver health services; and
- In the long term, to plan and build sufficient physical capacity to meet future needs for health services.

The majority of AHS's operating funds are from AHW. AHW provides the operating funds on the first of each month. AHS monitors and forecasts its working capital and cash flow as part of its ongoing cash management activities.

AHW approves health care facilities based on long-term capital plans and AI provides the majority of the funding through one-time capital grants. AHS funds the required equipment and systems by a combination of allocating a portion of operating funds and obtaining external funding from charitable donations and capital grants. AHS borrows to finance capital investments related to ancillary operations, which includes parking and rental operations, non-patient food services and the sale of goods and services, since AHW and AI do not fund ancillary operations.

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2012
(thousands of dollars)

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS complied with all debt covenants during the year. In the event of default, the entire outstanding indebtedness secured by and payable to Alberta Capital Financing Authority (ACFA), at their option, becomes due and payable forthwith and without notice to AHS. ACFA may also elect to retain all or any part of the collateral in satisfaction of the indebtedness of AHS. AHS monitors and forecasts all debt covenants as part of its ongoing debt management activities.

Where AHS has incurred an accumulated deficit, legislation requires submission of a deficit elimination plan.

(n) Changes to Accounting Framework

The Public Sector Accounting Board of the CICA has issued a framework for financial reporting by government not-for-profit organizations. This framework will be effective for fiscal periods beginning on or after January 1, 2012.

Effective April 1, 2012, AHS will adopt the Canadian Public Sector Accounting (PSA) standards without the Public Sector 4200 series. Adopting these new standards will impact AHS's consolidated financial statements. AHS has developed a PSA transition plan and has identified the major differences between current and PSA accounting and reporting standards. Two of these differences include:

- Sick leave obligations – AHS will be required to record accumulating non-vesting sick leave obligations.
- Controlled foundations – AHS will be required to consolidate its controlled foundations currently disclosed in Note 21(c)(i).

AHS continues to work through this transition and the remaining differences; the quantitative impact cannot be fully and reasonably determined at this time.

Note 3 Restatements

(a) Long-term Care Partnerships Adjustment

In prior years, AHS accounted for loans advanced to contracted health service providers under the Forgivable Mortgage Model. Under this model, advances were recognized as assets amortized over the useful life of the funded infrastructure and expensed to facility-based continuing care services and community based care. If the loans were provided from funds contributed to AHS, an equal amount of revenue was recognized as other government contributions from deferred contributions.

AHS has determined that forgivable mortgages are in substance contributions by AHS to contracted health service providers and, therefore, it is more appropriate to expense the advances when the forgivable mortgage contracts create an obligation and to recognize an equal amount of revenue from deferred contributions. Consistent with this conclusion, AHS has also determined that commitments to make payments to contracted health service providers under the Supplementary Payments Model should be expensed and recorded as a liability when the contracts create an obligation.

Note 3 Restatements (continued)

(b) Full Cost Adjustment

In prior years, AHS accounted for revenue earned by contracted health service providers from AHW designated fees and charges as AHS fees and charges and recorded an equivalent amount as program expenses on the basis that this revenue funded part of the cost of AHS's programs. As AHS is not entitled to these fees and charges, AHS has concluded it is not appropriate to gross up these fees and charges on AHS's financial statements. Consistent with this conclusion, AHS has also determined that grossing up government contributions and program expenses for the estimated cost for use of acute care facilities not owned by AHS is not appropriate.

(c) Commitments and Contingencies

In 2012, AHS changed its contingencies disclosure reporting practice to disclose only those legal claims, where:

- it is likely that a future event will confirm a contingent loss at the date of the financial statements but the amount of loss cannot be reasonably estimated;
- the occurrence of a future event confirming a contingent loss is not reasonably determinable; or
- the occurrence of the confirming future event is likely and an accrual has been made but there exists an exposure to loss in excess of the amount accrued.

As a result of this change, the prior year figures for claims disclosed in Note 20(d) have been reduced from 361 claims ($325,490) to 114 claims ($145,943).

(d) Reclassifications

Certain 2011 amounts have been reclassified to conform to the 2012 presentation.

The impact on the prior year's consolidated financial statements as a result of these restatements is presented in Schedule 4.

Note 4 Budget

The 2011/2012 Operating Budget and Business Plan with a budgeted deficit of $20,000, was approved by the Board on June 10, 2011 and the full financial plan was submitted to the Minister. The reported budget reflects the original $20,000 deficit and additional reclassifications required for more consistent presentation with current and prior year results (Schedule 3), including restatements for long-term care partnerships (Note 3(a)) and full cost (Note 3 (b)).

Note 5 Unrestricted Deficit Funding

AHS started on April 1, 2009 with an opening accumulated deficit from the former health entities. In February 2010 the five-year funding commitment for health was announced, including funding the accumulated deficit of AHS after the first year of operations. In the prior year, $527,235 in deficit funding was received as a part of this commitment.

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2012
(thousands of dollars)

Note 5 Unrestricted Deficit Funding (continued)

The Consolidated Statement of Operations reports the operating surplus including the deficit funding. The operating surplus excluding the deficit funding is as follows:

	2012	2011
Operating surplus	$ 84,591	$ 856,155
Less: Deficit funding	-	(527,235)
Operating surplus excluding deficit funding	$ 84,591	$ 328,920

Note 6 Investment and Other Income

	2012	2011 Restated (Note 3)
Investment income	$ 36,631	$ 69,799
Other income:		
External recoveries	125,911	140,542
Grants and other revenue	67,631	57,026
Purchase incentives and rebates	18,126	7,842
	$ 248,299	$ 275,209

Note 7 Administration Expense

	2012	2011 Restated (Note 3)
General administration[(a)]	$ 134,992	$ 92,810
Human Resources	104,109	90,119
Finance	67,781	62,845
Administration - contracts with health service providers	57,039	58,451
	$ 363,921	$ 304,225

(a) General Administration

General administration includes senior executive and administrative functions such as communications, planning and development, privacy, risk management, internal audit, infection control, quality assurance, insurance, patient safety, and legal. Activities and costs directly supporting clinical activities are excluded.

Note 8 Pension Expense

	2012	2011 Restated (Note 3)
Local Authorities Pension Plan (LAPP)[a]	$ 361,575	$ 321,919
Defined contribution pension plans and Group RRSPs	16,772	12,922
Costs to transfer employees to LAPP	5,169	-
Supplemental Executive Retirement Plans	3,770	3,351
Management Employees Pension Plan (MEPP)[b]	661	90
Supplemental Pension Plan	523	458
	$ 388,470	$ 338,740

(a) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP and as AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

The LAPP provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE) over the same five consecutive year period and 2.0% on the excess, subject to the maximum pension benefit limit allowed under the *Income Tax Act* (Canada). The maximum pensionable service allowable under the plan is 35 years.

The contribution rates were reviewed by the LAPP Board of Trustees in 2011 and are to be reviewed at least once every three years based on recommendations of the LAPP's actuary. AHS and its employees made the following contributions:

Calendar 2011		Calendar 2010	
Employer	Employees	Employer	Employees
$ 357,632	$ 324,613	$ 314,219	$ 284,303
9.49% of pensionable earnings up to the YMPE and 13.13% of the excess	8.49% of pensionable earnings up to the YMPE and 12.13% of the excess	9.06% of pensionable earnings up to the YMPE and 12.53% of the excess	8.06% of pensionable earnings up to the YMPE and 11.53% of the excess

AHS contributed $357,632 (2010 - $314,219) of the LAPP's total employer contributions of $856,950 from January 1, 2011 to December 31, 2011 (December 31, 2010 - $777,766).

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2012
(thousands of dollars)

Note 8 Pension Expense (continued)

(ii) LAPP Deficit

An actuarial valuation of the LAPP was carried out as at December 31, 2010 by Mercer (Canada) Limited and results were then extrapolated to December 31, 2011. LAPP's net assets available for benefits divided by LAPP's pension obligation shows that LAPP is 81% (2010 – 79%) funded.

	December 31, 2011	December 31, 2010
LAPP net assets available for benefits	$ 19,662,810	$ 17,686,850
LAPP pension obligation	24,302,200	22,322,100
LAPP deficit	$ (4,639,390)	$ (4,635,250)

Further information about the LAPP including assumptions and sensitivities of the LAPP's deficiency to changes in those assumptions can be found in the LAPP financial statements and the LAPP annual report.

The 2012 and 2013 LAPP contribution rates have been increased as follows:

Calendar 2013 (estimated)		Calendar 2012	
Employer	Employees	Employer	Employees
10.43% of pensionable earnings up to the YMPE and 14.47% of the excess	9.43% of pensionable earnings up to the YMPE and 13.47% of the excess	9.91% of pensionable earnings up to the YMPE and 13.74% of the excess	8.91% of pensionable earnings up to the YMPE and 12.74% of the excess

(b) Management Employees Pension Plan (MEPP)

At December 31, 2011 the MEPP reported a deficit of $517,726 (2010 – deficit of $397,087).

Note 9 Cash, Cash Equivalents and Investments

	2012		2011	
	Fair Market Value	Cost	Fair Market Value	Cost
Cash	$ 504,538	$ 504,538	$ 457,951	$ 457,951
Money market securities < 90 day maturity	258,823	258,823	614,132	614,132
Money market securities > 90 day maturity	73,267	73,267	-	-
Fixed income securities	1,288,582	1,281,964	1,220,750	1,230,108
Equities	27,038	27,057	27,967	25,678
	$ 2,152,248	$ 2,145,649	$ 2,320,800	$ 2,327,869
Classified for Financial Instruments as:				
Available for sale	$ 2,030,581	$ 2,025,665	$ 2,225,985	$ 2,235,095
Held for trading	121,667	119,984	94,815	92,774
	$ 2,152,248	$ 2,145,649	$ 2,320,800	$ 2,327,869

Classified on the Consolidated Statement of Financial Position as:		
Current cash	$ 299,877	$ 150,011
Money market securities < 90 day maturity	258,823	614,132
Current cash and cash equivalents	558,700	764,143
Current investments	1,217,043	957,322
Non-current cash and investments	376,505	599,335
Total cash, cash equivalents and investments	$ 2,152,248	$ 2,320,800

In order to earn optimal financial returns at an acceptable level of risk, AHS has established an investment bylaw with maximum asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities. Risk is reduced through asset class diversification, diversification within each asset class, and quality constraints on fixed income securities and equity investments.

(a) Interest Rate Risk

AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

Money market securities are comprised of Government of Canada, provincial and corporate treasury bills maturing June 2012 and bearing interest at an average effective yield of 1.00% (2011 – 0.74%) per annum.

Fixed income securities, such as bonds, have an average effective yield of 1.80% (2011 – 2.07%) per year, maturing between 2012 and 2044. The securities have the following maturity structure:

	2012	2011
1 – 5 years	87%	88%
6 – 10 years	10%	9%
Over 10 years	3%	3%

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Note 9 Cash, Cash Equivalents and Investments (continued)

(b) Currency Rate Risk

AHS is exposed to foreign exchange fluctuations on its investments denominated in foreign currencies. However, this risk is managed by the fact that AHS's investment bylaw limits non-Canadian equities to 25% of the total investment portfolio. As at March 31, 2012, investments in non-Canadian equities represented 0.50% (2011 – 0.57%) of total investments.

(c) Credit and Market Risks

AHS is exposed to credit risk from the potential non-payment of accounts receivable. However, the majority of the value of AHS's receivables is from AHW; therefore credit risk is considered to be minimal.

AHS's investment by-law restricts the types and proportions of eligible investments, thus mitigating AHS's exposure to market risk. Money market securities are limited to a rating of R1 or equivalent or higher and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total investment portfolio. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. Short selling is not permitted.

(d) Restricted Funds for Long Term Insurance Obligations

Included in restricted funds are cash and investments held by AHS to meet long term liability and property insurance obligations. Amounts totaling $96,472 (2011 - $85,386) are restricted to satisfy the reserve and guarantee funds requirement under the *Insurance Act* (Alberta) related to the provision for unpaid claims (Note 16(a)).

(e) Restricted Cash

Current cash and cash equivalents and current investments include a restricted amount of $723,695 (2011 - $550,555), and non-current cash and investments includes $204,661 (2011 - $307,940) of restricted cash and $171,844 of restricted investments (2011 - $291,395).

Note 10 Capital Assets

	2012		
	Cost	Accumulated Amortization	Net Book Value
Facilities and improvements	$ 6,138,968	$ 2,293,008	$ 3,845,960
Work in progress	2,109,881	-	2,109,881
Equipment	1,898,642	1,282,031	616,611
Information systems	932,565	646,573	285,992
Building service equipment	381,646	216,804	164,842
Land	109,429	-	109,429
Leased facilities and improvements	165,013	97,007	68,006
Land improvements	64,753	50,303	14,450
	$ 11,800,897	$ 4,585,726	$ 7,215,171

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Note 10 Capital Assets (continued)

	2011		
	Cost	Accumulated Amortization	Net Book Value
Facilities and improvements	$ 6,001,128	$ 2,118,659	$ 3,882,469
Work in progress	1,669,214	-	1,669,214
Equipment	1,740,143	1,160,474	579,669
Information systems	757,329	541,302	216,027
Building service equipment	349,066	194,307	154,759
Land	108,830	-	108,830
Leased facilities and improvements	162,892	81,900	80,992
Land improvements	63,512	48,008	15,504
	$ 10,852,114	$ 4,144,650	$ 6,707,464

(a) Leased Land

Land at the following sites has been leased to AHS at nominal values:

Site	Leased from	Lease expiry
Cross Cancer Institute parkade	University of Alberta	2019
Banff Health Unit	Mineral Springs Hospital	2028
Evansburg Community Health Centre	Yellowhead County	2031
Two Hills helipad	Stella Stefiuk	2041
Northeast Community Health Centre	City of Edmonton	2046
Foothills Medical Centre parkade	University of Calgary	2054
McConnell Place North	City of Edmonton	2056
Alberta Children's Hospital	University of Calgary	2101

(b) Work in Progress

During the year Alberta Infrastructure contributed $495,328 (2011 - $105,966) of in-kind work in progress to AHS.

(c) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $11,496 (2011 - $12,250) with accumulated amortization of $10,721 (2011 - $10,938).

Note 11 Other Assets

	2012	2011 Restated (Note 3)
Capital contributions receivable	$ 92,175	$ 76,937
Accrued benefit asset of SERPs [(a)]	11,636	12,511
Other non-current assets	25,682	6,656
	$ 129,493	$ 96,104

(a) Supplemental Executive Retirement Plans (SERPs)

During the year there were three SERPs sponsored by AHS. Under their terms, participants will receive retirement benefits that supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). As required under the plans' terms, any unfunded obligations identified in the actuarial valuation completed at the end of each fiscal year must be fully funded within 61 days. The accounting policies for SERPs are described in Note 2(h).

During 2012, the AHS Board approved amendments to the defined benefit SERPs which will freeze SERP service accruals and earnings projections for all active plan members over a 3 year period. Once individual plan members' SERP service accruals are frozen, these plan members will be enrolled and accrue benefits in the new defined contribution SPP. The plan amendments described above meet the definition of a curtailment event. The curtailment event resulted in a decrease to the accrued benefit obligation of $1,251 and a corresponding $1,251 decrease in unrecognized net actuarial losses.

	2012	2011
Change in accrued benefit obligation		
Accrued benefit obligation, beginning of year	$ 34,143	$ 31,809
Current service cost	1,774	1,668
Interest cost	1,704	1,754
Benefit payments	(1,956)	(2,159)
Decrease in obligation due to curtailment	(1,251)	-
Actuarial losses	771	1,071
Accrued benefit obligation, end of year	$ 35,185	$ 34,143
Change in plan assets		
Fair value of plan assets, beginning of year	$ 40,095	$ 32,367
Adjustment to opening value	932	(984)
Actual return on plan assets	1,738	1,189
Actual employer contributions	2,895	9,682
Benefit payments	(1,956)	(2,159)
Fair value of plan assets, end of year	$ 43,704	$ 40,095
Reconciliation of funded status to accrued benefit asset		
Funded status of the plan	$ 8,519	$ 5,952
Unrecognized net actuarial losses	3,008	5,921
Unrecognized initial obligations	57	342
Unrecognized past service cost	52	296
Accrued benefit asset, end of year	$ 11,636	$ 12,511

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Note 11 Other Assets (continued)

	2012	2011
Determination of net benefit cost		
Current service cost	$ 1,774	$ 1,668
Interest cost	1,704	1,754
Net return on plan assets	58	(887)
Net actuarial losses (gains) in year	(295)	166
Amortization of initial obligations and past service costs	529	650
Plan amendment – curtailment	(1,251)	-
Accelerated recognition of unamortized actuarial loss due to curtailment	1,251	-
Net benefit cost	$ 3,770	$ 3,351
Members		
Active	51	60
Retired and terminated	52	48
Total members	103	108
Assumptions		
Weighted average discount rate to determine year end obligations	4.80%	4.90%
Weighted average discount rate to determine net benefit costs	4.90%	5.40%
Expected return on assets	2.13%	2.70%
Expected average remaining service life time	3	5
Rate of compensation increase per year	3.5% for 2012 until notice period end date	2011-2012 1.5% 2012-2013 2.5% Thereafter 3.5%

Note 12 Deferred Contributions

Deferred contributions represent unspent externally restricted resources. Changes in the deferred contributions balance are as follows:

	2012			2011
	AHW	Others	Total	Total Restated (Note 3)
Balance beginning of the year	$ 415,322	$ 192,299	$ 607,621	$ 576,034
Received or receivable during the year	695,868	174,557	870,425	947,954
Restricted investment income	2,561	1,719	4,280	6,090
Transferred from (to) deferred capital contributions	(4,192)	11,614	7,422	2,123
Contribution and investment income recognized as revenue	(838,227)	(201,161)	(1,039,388)	(924,580)
Balance end of the year	$ 271,332	$ 179,028	$ 450,360	$ 607,621

Note 12 Deferred Contributions (continued)

The balance at the end of the year is restricted for the following purposes:

	2012			2011
	AHW	Others	Total	Total Restated (Note 3)
Research and education	$ 1,813	$ 79,363	$ 81,176	$ 79,278
Addiction and mental health	77,544	1,618	79,162	109,470
Primary Care Networks (Note 21(b))	41,946	622	42,568	41,946
Virtual site training for Calgary South Health Campus	41,982	-	41,982	49,630
Cancer prevention, screening and treatment	32,922	4,329	37,251	38,329
Physician revenue and Alternate Relationship Plans	28,305	-	28,305	54,410
Infrastructure maintenance	22	26,776	26,798	38,205
Promotion, prevention and community	18,002	4,532	22,534	40,980
Administration and support services	421	14,565	14,986	12,135
Continuing care and seniors health	11,494	2,495	13,989	52,620
Inpatient acute nursing services	937	12,796	13,733	19,426
Emergency and outpatient services	7,642	5,210	12,852	21,049
Diagnostic and therapeutic services	1,978	8,292	10,270	12,305
Information technology	3,308	297	3,605	15,369
Others less than $10,000	3,016	18,133	21,149	22,469
	$ 271,332	$ 179,028	$ 450,360	$ 607,621

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Note 13 Deferred Capital Contributions

Deferred capital contributions represent unspent externally restricted resources related to capital assets. Changes in the deferred capital contributions balance are as follows:

	2012				2011
	AHW	AI	Others	Total	Total
Balance beginning of the year	$ 214,607	$ 267,281	$ 59,968	$ 541,856	$ 1,046,140
Received or receivable during the year	40,867	35,901	67,589	144,357	156,757
Received in kind	-	495,328	-	495,328	106,052
Restricted investment income	1,889	-	-	1,889	965
Capital contributions returned[a]	(7,917)	(81,441)	(7,842)	(97,200)	(58,850)
Transferred to unamortized external capital contributions	(60,067)	(619,959)	(38,864)	(718,890)	(710,815)
Transferred from (to) deferred contributions	4,192	(14,551)	2,937	(7,422)	(2,123)
Other	-	-	-	-	3,730
Balance end of the year	$ 193,571	$ 82,559	$ 83,788	$ 359,918	$ 541,856

(a) Payment to AI for capital contribution returned did not occur by March 31, 2012.

Note 13 Deferred Capital Contributions (continued)

The balance at the end of the year is restricted for the following purposes

	2012	2011
AHW		
Information systems:		
Regional Shared Health Information Program	$ 34,540	$ 44,979
Diagnostic Imaging Project Year 3	25,844	29,004
Diagnostic Imaging Project Year 4	22,142	26,219
Provincial Health Information Exchange	9,128	10,909
Others less than $10,000	71,248	75,971
	162,902	187,082
Equipment less than $10,000	30,669	27,525
Total AHW	193,571	214,607
AI		
Facilities and improvements:		
Infrastructure maintenance projects	38,868	143,009
Others less than $10,000	43,691	124,272
Total AI	82,559	267,281
Other		
Equipment less than $10,000	74,495	31,155
Facilities and improvements less than $10,000	9,293	28,813
Total Other	83,788	59,968
Total	$ 359,918	$ 541,856

Note 14 Long-term Debt

	2012	2011
Debentures payable: [a]		
Parkade loan #1	$ 44,528	$ 46,683
Parkade loan #2	40,510	42,303
Parkade loan #3	49,744	51,582
Parkade loan #4	178,292	15,000
Parkade loan #5	10,000	5,000
Calgary Laboratory Services purchase	10,179	16,583
Term loan-Parkade #4	-	138,000
Term loan-Parkade #5 [b]	19,000	2,000
Obligation under capital lease [c]	15,280	15,328
Other	2,446	3,820
	$ 369,979	$ 336,299
Current	$ 38,802	$ 153,799
Non-current	331,177	182,500
	$ 369,979	$ 336,299
Fair value of total long-term debt [d]	$ 423,165	$ 345,325

(a) AHS issued debentures to ACFA, a related party, to finance the construction of parkades and the purchase of the remaining 50.01% ownership interest in CLS. AHS has pledged as security for these debentures revenues derived directly or indirectly from the operations of all parking facilities being built, renovated, owned and operated by AHS.

As at March 31, 2012, $10,000 (2011 - $5,000) of $42,300 has been advanced to AHS relating to the Parkade loan #5 debenture with the remaining to be drawn by June 1, 2012. Semi-annual principal payments of $1,577 will commence December 1, 2012.

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Calgary Laboratory Services purchase	May 2013	4.6810%

(b) AHS obtained a term loan facility of $42,300 during 2011, of which $19,000 (2011 - $2,000) has been drawn at March 31, 2012. The facility has been secured by the issuance of the Parkade #5 debenture to ACFA. Although the loan is repayable on demand, repayment terms are for monthly payment of interest only at 2.89%, with the full principal repayment due upon maturity on June 1, 2012.

(c) The capital lease with the University of Calgary expires January 2028. The implicit interest rate payable on this lease is 6.5%.

(d) The fair value of long-term debt is estimated based on market interest rates from ACFA for debentures of similar maturity. AHS manages the interest rate risk exposure of its long-term debt by concentrating the majority of its financial liabilities in fixed rate debt, which provides stable and predictable cash outflows.

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Note 14 Long-term Debt (continued)

(e) As at March 31, 2012 AHS held a $220,000 revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.5% per annum. As at March 31, 2012, AHS has no draws against this facility.

AHS also holds a $33,000 revolving demand letter of credit facility which may be used to secure AHS's obligations to third parties relating to construction projects and SERPs. As at March 31, 2012, AHS had $5,353 (2011 - $6,024) in letters of credit outstanding against this facility.

AHS is committed to making payments as follows:

Year ended March 31	Debentures Payable, Term/Other Loan and Mortgages Payable Principal payments	Capital Lease Minimum lease payments
2013	$ 38,286	$ 1,827
2014	17,347	1,693
2015	14,533	1,532
2016	15,221	1,453
2017	15,943	1,453
Thereafter	253,369	16,845
	$ 354,699	24,803
Less: interest		9,523
		$ 15,280

During the year, the amount of interest expensed was $9,009 (2011 - $7,954).

The principal payments due in 2013 for lease payments are $856.

Note 15 Unamortized External Capital Contributions

Unamortized external capital contributions at year-end represent the external capital contribution to be recognized as revenue in future years. Changes in the unamortized external capital contributions balance are as follows:

	2012	2011
Balance beginning of year	$ 5,598,973	$ 5,254,711
Transferred from deferred capital contributions	718,890	710,815
Less deferred capital contributions used for the purchase of land	(599)	(2,500)
Less amounts recognized as revenue:		
Amortized external capital contributions:		
Equipment	(113,893)	(129,551)
Information systems	(39,167)	(52,326)
Facilities and improvements	(189,245)	(182,304)
Ancillary operations	(245)	(425)
Other	-	553
Balance end of year	$ 5,974,714	$ 5,598,973

Note 16 Other Liabilities

	2012	2011 Restated (Note 3)
Provision for unpaid claims [(a)]	$ 101,619	$ 76,802
Long-term care partnerships [(b)]	23,875	34,575
Life lease deposits [(c)]	12,363	12,814
Asset retirement obligations [(d)]	4,852	11,058
Other	5,010	9,291
	$ 147,719	$ 144,540

(a) Provision for Unpaid Claims

Provision for unpaid claims represents the losses from identified claims likely to be paid and provisions for liabilities incurred but not yet reported. The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals, on historical precedent and trends, on prevailing legal, economic, and social and regulatory trends, and on expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materiality from the best estimates made.

The fair value of unpaid claims is not practicable to determine with sufficient reliability. Under accepted actuarial practice, the appropriate value of the claims liabilities is the discounted value of such liabilities plus the provision for adverse deviation. The provision for unpaid claims has been estimated using the discounted value of claim liabilities using a discount rate of 2.10% (2011 – 3.25%).

(b) Long-term Care Partnership Agreements

Under some long-term care partnership agreements, AHS makes annual payments to the partner over the term of the partnership contract, which is usually the expected useful life of the infrastructure. Amounts invested under the terms of long-term care partnership agreements will be utilized to fund future payments to providers over the next 22 years. These payments have a net present value of $23,438 at March 31, 2012 (2011 - $20,695) discounted at 2.6% (2011 – 3.7%).

(c) Life Lease Deposits

Funding for the Laurier House facilities, a project for long-term care residents in Edmonton, is provided by the tenants with a non-interest bearing repayment deposit, for the right to occupy the unit they are leasing. When the life lease agreement is terminated, which may be by death of the tenant or the tenant moving out, the life lease deposit is returned to the tenant without interest and in accordance with the terms of the Life Lease Agreement. The liability for life lease deposits is based on a discharge rate of 25% (2011 – 25%) and a discount rate of 1.65% (2011 - 2.2%), representing the bank secured lending rate. The reported liability is based on estimates and assumptions with respect to events extending over a 4 year period using the best information available to management. The carrying value of the reported liability approximates fair value.

Note 16 Other Liabilities (continued)

(d) Asset Retirement Obligation

The asset retirement obligation (ARO) represents the legal obligation associated with the removal of asbestos during planned renovations of AHS facilities. The total undiscounted amount of the estimated cash flows required to settle the recorded obligation is $4,928 (2011 - $11,125), which has been discounted using a weighted average credit-adjusted risk free rate of 1.7% (2011 - 2.2%). Payments to settle the ARO are expected to occur by 2013. AHS has identified the existence of asbestos in other buildings which is not required to be remediated at this time and therefore is not recorded as an obligation.

Note 17 Other Internally Restricted Net Assets

	2012	2011
South Health Campus [a]	$ 45,016	$ 50,000
Parkade infrastructure reserve [b]	24,522	16,722
	$ 69,538	$ 66,722

(a) The AHS Board has approved the restriction of operating surplus to assist with funding start up costs for South Health Campus in Calgary.

(b) The AHS Board has approved the restriction of parking services surpluses to establish a parking infrastructure reserve for future major maintenance, upgrades and construction.

Note 18 Endowments

	2012	2011
Cancer Research Institute of Alberta Director Research Chair [a]	$ 10,000	$ 10,000
J.K. Bigelow Education Fund [b]	150	150
	$ 10,150	$ 10,150

(a) The Cancer Research Institute of Alberta (CRIA) Director Research Chair endowment is internally restricted and is designated for use as a Research Chair for the Director of CRIA. The principal amount of $10,000 is required to be maintained and all investment proceeds are available for use. Investment proceeds from the fund are used for the salary, infrastructure and operating grant support for the CRIA Director Research Chair.

(b) The J.K. Bigelow Education Fund endowment is internally restricted and is designated for funding of health related courses undertaken by employees of AHS in the Lethbridge area. The principal amount of $150 is required to be maintained and all investment proceeds are available for use. Investment proceeds from the fund are used for education.

Note 19 Changes in Non-Cash Working Capital

The increase (decrease) in non-cash working capital is comprised of:

	2012	2011 Restated (Note 3)
Current investments	$ (259,721)	$ (738,403)
Accounts receivable	(37,464)	(34,486)
Contributions receivable from AHW	122,060	(121,080)
Inventories	2,357	9,242
Prepaid expenses	(154)	(4,043)
Accounts payable and accrued liabilities	61,324	183,578
Accrued vacation pay	42,621	18,338
Deferred contributions	(157,261)	25,438
	$ (226,238)	$ (661,416)
Related to:		
Operating	$ (245,106)	$ (737,874)
Investing	18,868	76,458
	$ (226,238)	$ (661,416)

Note 20 Commitments and Contingencies

(a) Leases

AHS is contractually committed to future operating lease payments for premises and vehicles until 2029 and 2017 respectively as follows:

	Premises	Vehicles	Total
2013	$ 43,140	$ 2,848	$ 45,988
2014	32,627	2,269	34,896
2015	29,395	1,776	31,171
2016	25,085	639	25,724
2017	20,786	20	20,806
Thereafter	58,704	-	58,704
	$ 209,737	$ 7,552	$ 217,289

(b) Capital Assets

AHS has the following outstanding contractual commitments for capital assets as of March 31:

	2012
Equipment	$ 114,039
Facilities and improvements	85,353
Information systems	49,663
	$ 249,055

Note 20 Commitments and Contingencies (continued)

(c) Contracted Health Service Providers

AHS contracts on an ongoing basis with voluntary and private health service providers to provide health services in Alberta as disclosed in Note 21(d). AHS has contracted for services in the year ending March 31, 2013 similar to those provided by these providers in 2012.

(d) Contingencies

AHS is subject to legal claims during its normal course of business. AHS records a liability when the assessment of a claim indicates that a future event is likely to confirm that an asset had been impaired or a liability incurred at the date of the financial statements and the amount of the contingent loss can be reasonably estimated.

At March 31, 2012, AHS has been named in 7 claims (2011 – 14 claims) where it is likely that a future event will confirm a contingent loss. The amount of loss cannot be reasonably estimated and no liability is recorded for these claims (2011 – nil). At March 31, 2012, AHS has been named in 158 legal claims (2011 – 100 claims) where the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 137 claims have $234,873 in specified amounts and 21 have no specified amounts (2011 – 84 claims with $145,943 of specified claims and 16 claims with no specified amounts).

AHS has been named as a defendant in a legal action in respect of increased long-term care accommodation charges levied since August 1, 2003. The claim has been filed against the Government of Alberta and the former Regional Health Authorities (now AHS). The amount of the claim has not been specified but has been estimated to be between $100,000 and $175,000 per year based on the amount of the increases in accommodation charges levied, starting August 1, 2003. The outcome of the claim is not determinable at this time.

AHS has a contingent liability in respect of a claim relating to the failure of St. Joseph's Hospital to provide adequate infection control and safety measures to prevent contamination of medical equipment. The total amount of this claim is $25,000. The outcome of the claim is not determinable at this time.

Note 21 Related Parties

Transactions with the following related parties are considered to be in the normal course of operations. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

(a) Government of Alberta

The Minister of Health and Wellness appoints the AHS Board members. AHS is economically dependent on AHW since the viability of its operations depends on contributions from AHW. Transactions between AHS and AHW are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements.

Note 21 Related Parties (continued)

AHS shares a common relationship and is considered to be a related party with those entities consolidated or included on a modified equity basis in the Province of Alberta's financial statements. Transactions in the normal course of operations between AHS and the other ministries are recorded at their exchange amount as follows:

	Revenue		Expenses	
	2012	2011	2012	2011
Ministry of Advanced Education [i]	$ 50,364	$ 24,298	$ 125,806	$ 121,472
Ministry of Infrastructure [ii]	42,218	37,641	16	539
Other ministries	47,814	28,579	24,571	19,630
Total for the year	$ 140,396	$ 90,518	$ 150,393	$ 141,641

	Receivable from		Payable to	
	2012	2011	2012	2011
Ministry of Advanced Education [i]	$ 36,734	$ 5,396	$ 21,714	$ 24,219
Ministry of Infrastructure [ii]	61,886	39,227	151,248	12,951
Other ministries	6,429	9,630	338,571	180,572
Balance at end of the year	$ 105,049	$ 54,253	$ 511,533	$ 217,742

(i) Most of AHS transactions with the Ministry of Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of grants provided from one to the other and recoveries of shared cost.

(ii) The transactions with the Ministry of Infrastructure relate to the construction and funding of capital assets (Notes 10(b) and 13).

Note 21 Related Parties (continued)

(b) Primary Care Networks

AHS has joint control with various physician groups over Primary Care Networks (PCNs). AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services. Effective April 1, 2011, the Tri-Lateral Master Agreement between AHS, AHW and Alberta Medical Association expired. While a new agreement is currently being discussed, the joint venture agreements continue to direct the management and operation of the PCNs.

There are two legal models of PCNs, both of which are considered to be non-profit organizations under the income tax legislation. Legal model 1 consists of a joint venture agreement between AHS and the Physician non-profit corporation (NPC) with funding flowing to the Physician NPC from AHW. Legal model 2 is a PCN NPC owned equally by AHS and the Physician NPC with funding flowing to the PCN NPC from AHW. Individual physicians contract with the Physician NPC.

As a requirement of AHW, PCNs can only use accumulated surpluses based on an approved surplus reduction plan, and as such, AHS's proportionate share of these surpluses has been recorded by AHS as restricted deferred contributions. The following PCNs are included in these consolidated financial statements under the proportionate consolidation method:

Alberta Heartland Primary Care Network
Athabasca Primary Care Network
Big Country Primary Care Network
Bonnyville / Aspen Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace River Primary Care Network
Provost/Consort Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith/Spirit River Primary Care Network
Sherwood Park-Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
St. Paul / Aspen Primary Care Network
Vermilion Primary Care Network
Wainwright Primary Care Network
West Peace Primary Care Network
WestView Primary Care Network
Wetaskiwin Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

Note 21 Related Parties (continued)

AHS's proportionate share of assets, liabilities, revenues and expenses of the PCNs is as follows:

	2012	2011
Total revenue	$ 74,454	$ 67,531
Total expenses	74,454	67,531
Surplus of revenue over expenses	$ -	$ -
Assets:		
Current	$ 46,077	$ 43,110
Non-current	4,450	4,029
Total assets	$ 50,527	$ 47,139
Liabilities:		
Current [(i)]	$ 50,527	$ 47,139
Total liabilities	$ 50,527	$ 47,139

(i) Included in liabilities are deferred contributions of $42,568 relating to AHS's proportionate share of the surplus (2011 - $41,946) (Note 12).

(c) Foundations

A large number of foundations provide donations of money and services to AHS to enhance health care in various communities throughout Alberta. This financial support to AHS is reflected in donations revenue and capital contributions. These foundations are registered charities under the *Income Tax Act* (Canada) and accordingly, are exempt from income taxes, provided certain requirements of the Income Tax Act are met.

(i) Controlled foundations

A number of foundations are considered to be controlled entities as AHS appoints all trustees for such foundations. Controlled foundations are not consolidated in these consolidated financial statements.

The Alberta Cancer Foundation (ACF) and the Calgary Health Trust (CHT) are the largest controlled foundations. The following aggregated financial results of ACF and CHT is presented using the same accounting policies as AHS:

	2012		2011	
	ACF	CHT	ACF	CHT
Revenue	$ 42,179	$ 34,889	$ 43,872	$ 40,634
Expenses	45,376	34,083	43,276	39,670
Operating surplus (deficiency) of revenue over expenses	$ (3,197)	$ 806	$ 596	$ 964
Total assets	$ 116,676	$ 92,095	$ 118,248	$ 87,572
Total liabilities[(1) (2)]	41,906	65,191	43,227	64,406
Net assets[(1) (2)]	$ 74,770	$ 26,904	$ 75,021	$ 23,166

Note 21 Related Parties (continued)

(1) In accordance with donor imposed restrictions ACF must maintain permanently $73,712 (2011 - $72,577) with the investment revenue earned to be used for purposes in accordance with the various purposes established by the donors or the Trustees. A further $39,715 (2011 - $40,780) included in liabilities are deferred contributions that must be used for the purpose of cancer research, prevention and screening initiatives, as well as patient care and support, education and equipment.

(2) In accordance with donor imposed restrictions CHT must maintain permanently $22,812 (2011 - $19,880) with the investment revenue earned to be used in accordance with the various purposes established by the donors or the Board. A further $53,668 (2011 - $53,371) included in liabilities are deferred contributions that must be used for the purpose of capital projects and medical equipment, patient care and program support and medical research.

Financial information for the remaining controlled foundations is not disclosed because AHS does not receive financial information from all these foundations on a timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. These foundations' financial statement balances are immaterial individually and in aggregate relative to AHS. The following are the remaining foundations controlled by AHS as at March 31, 2012:

Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Region Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Lacombe Hospital and Care Centre Foundation
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

Note 21 Related Parties (continued)

The following foundations are also considered controlled, but are in the process of being wound-up or are considered to be inactive:

Central Peace Hospital Foundation
Lakeland Regional Health Authority Foundation
Peace Health Region Foundation
Manning Community Health Centre Foundation
McLennan Community Health Care Foundation
Vermilion and Region Health and Wellness Foundation

(ii) Other foundations

AHS has an economic interest in a number of foundations as they raise and hold resources to support AHS. AHS appoints one board trustee for such foundations. Financial information for these foundations is not disclosed because AHS does not receive financial information from all these foundations on a consistent and timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. The following are the foundations that AHS has an economic interest in as of March 31, 2012:

Alberta Children's Hospital Foundation
Beaverlodge Hospital Foundation
Black Gold Health Foundation
Capital Care Foundation
Chinook Regional Hospital Foundation
Consort Hospital Foundation
Coronation Heath Centre Foundation
Daysland Hospital Foundation
Devon General Hospital Foundation
Drayton Valley Health Services Foundation
Drumheller Area Health Foundation
Fairview Health Complex Foundation
Glenrose Rehabilitation Hospital Foundation
High River District Health Care Foundation
Hinton Health Care Foundation
Hythe Nursing Home Foundation
Northern Lights Regional Health Foundation
Northwest Health Foundation
Provost and District Health Foundation
Queen Elizabeth II Hospital Foundation
Red Deer Regional Health Foundation
Regional EMS Foundation
Rosebud Health Foundation
Royal Alexandra Hospital Foundation
Sheep River Health Trust
St. Paul and District Hospital Foundation
Stollery Children's Hospital Foundation
Strathmore District Health Services Foundation
Sturgeon Community Hospital Foundation
Taber and District Health Foundation
Tri-Community Health and Wellness Foundation
University Hospital Foundation
Valleyview Health Complex Foundation
Wainwright and District Community Foundation
Wetaskiwin Health Foundation

Note 21 Related Parties (continued)

(d) Contracts with Health Service Providers

AHS is responsible for the delivery of health services in the Province. To this end, AHS contracts with various voluntary and private health service providers to provide health services throughout Alberta. The largest of these service providers is Covenant Health; the total amount funded to Covenant Health during the year was $640,982 (2011 - $617,083). As of March 31, 2012, the net book value of capital assets owned by AHS but operated by a voluntary or private health service provider was $137,592 (2011 - $138,036).

AHS has an economic interest through its contracts with certain voluntary and private health service providers as AHS transfers significant resources as follows:

	2012	2011 Restated (Note 3)
Direct funding by AHS to:		
Private Health Service Providers	$ 1,030,674	$ 988,251
Voluntary Health Service Providers	1,009,835	893,259
	$ 2,040,509	$ 1,881,510
Included in the Statement of Operations as follows:		
Inpatient acute nursing services	$ 269,975	$ 254,920
Emergency and other outpatient services	84,166	79,128
Facility-based continuing care services	540,009	496,807
Ambulance services	150,226	143,911
Community-based care	347,281	295,557
Home care	165,222	150,893
Diagnostic and therapeutic services	309,443	291,690
Promotion, prevention and protection services	7,517	7,831
Research and education	4,132	4,083
Administration	57,039	58,451
Information technology	469	490
Support services	105,030	97,749
	$ 2,040,509	$ 1,881,510

Alberta Health Services

Note 21 Related Parties (continued)

(e) Health Benefit Trust of Alberta

AHS is one of more than thirty participants in the Health Benefit Trust of Alberta (HBTA) and has a majority of representation on the HBTA governance board. The HBTA is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. The HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement. The HBTA uses various carriers for the different benefits. The HBTA is exempt from the payment of income taxes.

The HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $57,081 as at December 31, 2011 ($79,576 as at December 31, 2010). Under the terms of the Trust Agreement, no participating employer or eligible employee shall have any right to any surplus or assets of the Trust nor shall they be responsible for any deficits or liabilities of the Trust. However, AHS has included in prepaid expenses $41,494 (2011 - $44,118) as a share of the HBTA's fund balances representing in substance a prepayment of future contributions. For the period January 1 to December 31, 2011 AHS paid premiums of $232,162 (2011 - $132,121).

Note 22 Trust Funds

AHS receives funds in trust for research and development, education and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2012, the balance of funds held in trust by AHS for research and development is $9,308 (2011 - $7,263).

AHS also receives funds in trust from continuing care residents for personal expenses. These amounts are not included above and are not reflected in these consolidated financial statements.

Note 23 Approval of Consolidated Financial Statements

The consolidated financial statements have been approved by the Alberta Health Services Board.

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2012
(thousands of dollars)

SCHEDULE 1 - CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT
FOR THE YEAR ENDED MARCH 31, 2012

	2012		2011
	Budget (Note 4) (Schedule 3)	Actual	Actual Restated (Note 3) (Schedule 4)
Salaries and benefits (Schedule 2)	$ 6,315,000	$ 6,156,248	$ 5,667,428
Contracts with health service providers (Note 21(d))	2,108,000	2,040,509	1,881,510
Contracts under the Health Care Protection Act	19,000	18,434	19,308
Drugs and gases	362,000	387,984	361,468
Medical and surgical supplies	334,000	360,002	330,132
Other contracted services	1,065,000	1,038,221	974,356
Other*	1,093,000	1,221,259	1,060,243
Amortization**	495,000	474,513	470,511
TOTAL EXPENSES BY OBJECT	$ 11,791,000	$ 11,697,170	$ 10,764,956
* Significant amounts included in Other are:			
Building and ground expenses	$ 140,000	$ 170,581	$ 139,787
Equipment expense	146,000	152,498	155,690
Other clinical supplies	122,000	140,848	117,928
Utilities	112,000	108,354	100,614
Minor equipment purchases	58,000	104,090	93,903
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies	66,000	84,465	64,249
Office supplies	51,000	65,474	48,258
Food and dietary supplies	68,000	68,495	67,928
Building rent	37,000	51,718	28,852
Travel	46,000	49,719	48,758
Telecommunications	38,000	50,375	19,795
Insurance	21,000	42,670	20,646
Education	39,000	16,470	13,549
Licenses, fees and membership	18,000	15,453	17,564
Others less than $10,000	131,000	100,049	122,722
	$ 1,093,000	$ 1,221,259	$ 1,060,243
** Amortization expense:			
Internally funded equipment	$ 52,000	$ 59,869	$ 33,501
Internally funded information systems	49,000	48,801	48,656
Internally funded facilities and improvements	24,000	22,341	24,341
Externally funded equipment	125,000	111,970	129,379
Externally funded information systems	45,000	39,167	50,773
Externally funded facilities and improvements	200,000	189,646	181,420
Loss on disposal of assets	-	2,719	2,441
	$ 495,000	$ 474,513	$ 470,511

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2012

	2012								2011	
						Severance [e]				
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE [a]	Total [f,g]
Total Board	13.70	$ -	$ 699	$ -	$ 699	-	$ -	$ 699	13.37	$ 730
Total Executive	9.71	3,504	720	955	5,179	2	1,174	6,353	10.98	6,339
Management Reporting to CEO Reports	34.49	9,401	1,272	2,607	13,280	1	180	13,460	36.54	14,042
Other Management	3,808.28	412,821	9,829	85,490	508,140	69	3,732	511,872	3,479.87	446,389
Medical Doctors not included above	133.44	37,717	495	2,441	40,653	-	17	40,670	150.33	44,314
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	16,770.85	1,432,619	230,278	318,951	1,981,848	16	782	1,982,630	16,556.79	1,834,632
LPNs	3,574.86	212,011	33,141	44,854	290,006	4	272	290,278	3,349.26	255,914
Other Health Technical & Professionals	13,907.65	1,084,772	84,836	247,487	1,417,095	24	865	1,417,960	13,169.46	1,277,308
Unregulated Health Service Providers	6,642.88	301,937	44,018	64,297	410,252	17	372	410,624	6,303.75	347,093
Other Staff	21,649.37	1,175,179	65,776	231,931	1,472,886	140	3,647	1,476,533	21,560.54	1,440,667
Costs to transfer employees to LAPP	-	-	-	5,169	5,169	-	-	5,169	-	-
Total	**66,545.23**	**$ 4,669,961**	**$ 471,064**	**$ 1,004,182**	**$ 6,145,207**	**273**	**$ 11,041**	**$ 6,156,248**	**64,630.89**	**$ 5,667,428**

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

	Term	2012 Committees	2012 Honoraria	2011 Honoraria[7]
Board Chair				
Ken Hughes[1]	May 15, 2008 to Dec 28, 2011	AF, GOV, HA, HR, QS[6]	$ 63	$ 91
Catherine Roozen[2]	Since Jul 29, 2008	AF, GOV, HA, HR, QS[6]	60	57
Board Members				
Don Sieben[3]	Since May 15, 2008	AF(Chair), GOV, HA, HR, QS[6]	56	64
Dr. Ray Block[4]	Since Feb 18, 2011	HR	38	-
Teri Lynn Bougie	Since Nov 20, 2008	HA, QS (Vice-Chair)	54	54
Dr. Ruth Collins-Nakai	Since Feb 18, 2011	HR, QS	53	6
Dr. Kamalesh Gangopadhyay	Since Oct 13, 2010	GOV (Vice-Chair), QS	54	26
Don Johnson	Since Feb 18, 2011	AF (Vice-Chair), HA (Vice-Chair)	56	6
John Lehners	Since May 15, 2008	HA (Chair)	56	58
Irene Lewis	May 15, 2008 to Mar 15, 2012	HR (Chair)	50	51
Stephen Lockwood	Since Oct 13, 2010	GOV (Chair), HR (Vice-Chair)	52	25
Dr. Eldon Smith	Since Feb 18, 2011	AF, GOV	53	5
Sheila Weatherill[5]	Since Feb 18, 2011	AF, GOV	-	-
Gord Winkel	Since Nov 20, 2008	QS(Chair)	54	29
Jack Ady	May 15, 2008 to Aug 31, 2010	-	-	23
Lori Andreachuk	Nov 20, 2008 to Aug 31, 2010	-	-	28
Gord Bontje	Nov 20, 2008 to Nov 24, 2010	-	-	35
Jim Clifford	Nov 20, 2008 to Aug 31, 2010	-	-	23
Strater Crowfoot	Nov 20, 2008 to Mar 31, 2011	-	-	52
Tony Franceschini	Nov 20, 2008 to Nov 24, 2010	-	-	35
Linda Hohol	May 15, 2008 to Nov 25, 2010	-	-	34
Dr. Andreas Laupacis	Nov 20, 2008 to Nov 27, 2010	-	-	28
Total Board			$ 699	$ 730

Board members are compensated with monthly honoraria and honoraria for attendance at board and committee meetings in accordance with Ministerial Order #50. Although M.O. #50 was repealed by M.O. #93, original rates from M.O. #50 were adopted again as of January 1, 2010.

(1) Ken Hughes was Board Chair until December 28, 2011.
(2) Catherine Roozen was Board Vice Chair until being appointed Interim Board Chair from December 28, 2011 until March 15, 2012 at which time she was appointed Board Chair.
(3) Don Sieben was Interim Board Vice Chair from January 17, 2012 until March 15, 2012 at which time he was appointed Board Vice Chair.
(4) Dr. Ray Block started claiming honoraria on July 8, 2011.
(5) Sheila Weatherill does not claim honoraria.
(6) Board Chair and Board Vice Chair, including interims, are Ex-Officio Members on all Committees.
(7) Committee meeting fees were claimed by the Board members in the current year that related to prior year meetings. Therefore, the prior period was restated.

Committee legend: AF = Audit and Finance, GOV = Governance, HA = Health Advisory, HR = Human Resources, QS = Quality and Safety

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

For the Current Fiscal Year	2012										
	FTE	Base Salary (b)	Pay-at-Risk Component (b)	Other Variable Pay (b)	Vacation Payouts (b)	Other Cash Benefits (c)	Other Non-Cash Benefits (d)	Subtotal	Severance (e)	Total
Board Direct Reports										
President and Chief Executive Officer[h](j)(l)(y)	1.00	$ 580	$ 88	$ -	$ -	$ 21	$ 232	$ 921	$ -	$ 921
Chief Audit Executive[z]	1.00	200	24	-	-	-	43	267	-	267
Ethics and Compliance Officer[aa]	1.00	209	16	-	-	-	51	276	-	276
CEO Direct Reports										
Executive VP and Chief Operating Officer[h](m)(bb)	0.73	345	45	-	-	19	89	498	-	498
Executive VP and Chief Financial Officer[h](m)(bb)	0.27	105	16	-	-	7	33	161	-	161
Acting Chief Financial Officer[n](z)	0.38	128	19	-	-	1	27	175	-	175
Executive VP and Chief Medical Officer[h](k)(o)(cc)	1.00	481	61	-	30	24	173	769	-	769
Acting Executive VP and Chief Medical Officer[p](aa)	0.16	66	-	-	-	-	-	66	-	66
Executive VP and Chief Development Officer [h](q)(bb)	0.33	112	17	-	-	8	16	153	-	153
Executive VP, People and Partners[h](r)(bb)	0.54	221	35	-	-	18	39	313	-	313
Acting Executive VP, People and Partners[h](s)(bb)	0.46	185	29	-	-	14	48	276	-	276
Executive VP, Strategy and Performance[h](t)	0.78	288	45	-	6	31	49	419	436	855
Executive VP, Rural, Public and Community Health[h](u)	0.16	60	-	-	-	2	18	80	-	80
Executive VP and Executive Lead Transition[l](v)	0.90	335	58	-	52	6	78	529	738	1,267
Chief of Staff for the AHS Board[w](aa)	0.94	179	27	-	-	1	58	265	-	265
Chief of Staff, Board Office and VP Community Engagement[x](aa)	0.06	10	-	-	-	-	1	11	-	11
Total Executive	9.71	$ 3,504	$ 480	$ -	$ 88	$ 152	$ 955	$ 5,179	$ 1,174	$ 6,353

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

For the Prior Fiscal Year	2011										
	FTE	Base Salary (b)	Pay-at-Risk Component (b)	Other Variable Pay (b)	Vacation Payouts (b)	Other Cash Benefits (c)	Other Non-Cash Benefits (d)	Subtotal	Severance (e)	Total
Board Direct Reports										
President and Chief Executive Officer[f]	0.65	$ 383	$ -	$ 54	$ 29	$ 48	$ 3	$ 517	$ 681	$ 1,198
Acting President and Chief Executive Officer	0.35	167	-	25	43	4	43	282	-	282
Chief Audit Executive	0.76	151	21	-	-	-	18	190	-	190
Interim VP Internal Audit and Enterprise Risk Management - Contracted Services	0.24	113	-	-	-	-	-	113	-	113
Ethics and Compliance Officer[g]	1.00	209	16	-	-	-	35	260	-	260
CEO Direct Reports										
Executive VP and Chief Financial Officer	1.00	370	55	-	-	33	65	523	-	523
Executive VP, Corporate Services	1.00	370	60	-	-	27	60	517	-	517
Executive VP, Quality and Service Improvement	0.65	307	-	49	190	7	79	632	-	632
Executive VP and Acting Executive Lead for Quality and Service Improvement	0.33	159	-	27	-	-	19	205	-	205
Executive VP, Rural, Public and Community Health	1.00	370	-	62	-	1	106	539	-	539
Executive VP, Strategy and Performance	1.00	370	59	-	-	27	59	515	-	515
Executive VP, Clinical Support Services	1.00	365	-	65	16	2	60	508	-	508
Executive VP and Chief Medical Officer	0.67	323	-	52	92	-	40	507	-	507
Acting Executive VP and Chief Medical Officer	0.33	137	16	-	-	-	-	153	-	153
Chief of Staff, Board Office and VP Community Engagement	1.00	152	-	19	-	-	26	197	-	197
Total Executive	10.98	$ 3,946	$ 227	$ 353	$ 370	$ 149	$ 613	$ 5,658	$ 681	$ 6,339

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

Supplemental Pension Plan (SPP) and Supplemental Executive Retirement Plan (SERP)

	2012				2011				
	SPP	SERP							
	Current Service Costs (1)	Current Service Costs (2)	Other Costs (3)	Total	Total	Account Balance or Accrued Benefit Obligation March 31, 2011	Curtailment (Gain)/Loss (4)	Change During the Year (5)	Account Balance or Accrued Benefit Obligation March 31, 2012
President and Chief Executive Officer until April 1, 2011[f]	$ -	$ -	$ 87	$ 87	$ 172	$ 1,377	$ (68)	$ 61	$ 1,370
President and Chief Executive Officer from April 1, 2011[f]	44	-	-	44	-	-	-	44	44
Chief Audit Executive	6	-	-	6	5	5	-	6	11
Ethics and Compliance Officer	7	-	-	7	14	14	-	7	21
Executive VP and Chief Operating Officer / Executive Vice	30	-	-	30	46	46	-	31	77
Acting Chief Financial Officer[n]	17	-	-	17	-	14	-	17	31
Executive VP and Chief Medical Officer[o]	-	96	40	136	88	599	-	164	763
Acting Executive VP and Chief Medical Officer[p]	-	-	-	-	-	-	-	-	-
Executive VP and Chief Development Officer until November 30, 2011[q]	-	36	38	74	151	655	(56)	79	678
Executive VP and Chief Development Officer from December 1, 2011[q]	7	-	-	7	-	-	-	7	7
Executive VP, People and Partners[r]	15	-	-	15	-	-	-	15	15
Acting Executive VP, People and Partners[s]	23	-	-	23	40	40	-	23	63
Executive VP, Strategy and Performance[t]	18	-	-	18	32	32	-	(32)	-
Executive VP, Rural, Public and Community Health[u]	-	16	17	33	53	725	-	128	853
Executive VP and Executive Lead Transition[v]	-	66	7	73	30	294	(219)	96	171
Chief of Staff for the AHS Board[w]	5	-	-	5	-	-	-	5	5
Chief of Staff, Board Office and VP Community Engagement[x]	1	-	-	1	2	2	-	1	3

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service post 1991. The SPP is a defined contribution plan and the SERP is a defined benefit plan. The SERP is disclosed in Notes 2(h) and 11(a). The amounts in this table represent the total SPP and SERP benefits for the individual in the position listed whereas the amounts included in other non-cash benefits are prorated for the period of time the individual was in the position.

(1) The SPP current service costs are AHS contributions in the period.
(2) The SERP costs are not cash payments in the period but are the cost in the period for rights to these future retirement benefits. Current service cost is the actuarial present value of the benefits earned in the fiscal year.
(3) Other SERP costs include interest cost on the obligations and the amortization of past service cost, initial obligations and net actuarial gains and losses, offset by the expected return on the plans' assets.
(4) As a result of SERP plan amendments which occurred in the current year, an accounting curtailment event was recognized. This resulted in a decrease to the accrued benefit obligation but did not reduce the amount of benefits earned by plan members up to their end of notice period.
(5) Changes in the accrued benefit obligation include current service cost, interest accruing on the obligations, the full amount of any actuarial gains or losses in the period, and gains or losses due to curtailment.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

Definitions

a. For this schedule, Full time equivalents (FTE) are determined by actual hours paid divided by 2,022.75 annual base hours. If applicable, FTE for Board Members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year or the beginning of the year and the termination date. Total actual discrete number of individuals employed during the fiscal year was 106,141 (2011 – 99,386).

b. There are two compensation models for senior leaders. Some receive a base salary with a component that is at risk if they do not meet performance objectives. Others receive a base salary plus other variable pay if they meet performance objectives.

Pay at risk: As new staff is hired or existing contracts end, senior leaders are required to participate in 'pay-at-risk'. Under this model, a component of remuneration is withheld during the year and released (in full or in part) based on achievement of performance objectives.

Other variable pay: Senior leaders with contracts existing prior to formation of AHS may have variable pay provisions in their contracts. Variable pay is in addition to, and calculated as a percentage of, base salary. Variable pay is paid based on achievement of performance objectives.

Vacation payouts, which are a cash benefit, are shown separately for direct reports of the Board or President and Chief Executive Officer. Vacation accruals are included in base salary except for direct reports of the Board or President and Chief Executive Officer where it is included in other non-cash benefits.

c. Other cash benefits may include as applicable honoraria, overtime, automobile allowance, lump sum payments and an allowance for personal, financial and tax advice, club memberships and other similar purposes. For anyone other than direct reports of the Board or the President and Chief Executive Officer, other cash benefits may also include pay at risk or other variable pay if applicable.

d. Other non-cash benefits include:

- Employer's current and prior service cost of supplemental pension plan and supplemental executive retirement plans.
- Share of employee benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short term disability plans.
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

c. Severance includes direct or indirect payments to individuals upon termination or voluntary exit which are not included in other cash benefits or non-cash benefits.

f. In the prior year, severance of $661 was accrued for the incumbent. However, the final payment to the incumbent included an additional $20 for relocation expenses in accordance with the incumbent's contract. The prior year balance has been restated to reflect the actual severance paid.

g. Subsequent to release of the prior year financial statements, it was determined the incumbent's position should be retroactively included in a higher pay band which resulted in the position being eligible for pay at risk. Therefore, the incumbent was retroactively awarded pay at risk for fiscal 2011. The prior year balance has been restated to reflect the actual pay at risk paid.

h. Incumbents are provided with an automobile allowance. Dollar amounts are included in other cash benefits.

i. Incumbents are provided with an automobile. Dollar amounts are not included in other non-cash benefits.

j. Incumbent was on secondment from the University of Calgary until December 31, 2011. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary, honorarium and market supplements; all amounts have been included in base salary.

k. Incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary; all amounts have been included in base salary.

Appointments and Departures

l. Incumbent held the position of Acting President and Chief Executive Officer until March 31, 2011. Incumbent appointed to position of President and Chief Executive Officer effective April 1, 2012 to March 31, 2016.

m. Incumbent held the position of Executive Vice President and Chief Financial Officer until May 31, 2011 at which time the incumbent was appointed to Executive Vice President and Chief Financial Officer and Acting Chief Operating Officer. The Executive Vice President and Chief Operating Officer position was established effective June 1, 2011 as a result of restructuring. The incumbent received acting pay of 10% of the base salary for the Acting Chief Operating Officer position. The incumbent was appointed to Executive Vice President and Chief Operating Officer on July 11, 2011 and retained the position of Acting Chief Financial Officer until November 15, 2011. The incumbent received an increase in base salary for the Executive Vice President and Chief Operating Officer position. Pay at risk has been allocated to each position based on the performance agreement relating to each position.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

n. Incumbent held the position of Senior Vice President, Finance until November 16, 2011 at which time the incumbent was appointed to Acting Chief Financial Officer and became a direct report to the President and Chief Executive Officer. The incumbent received an additional 10% of the base salary for the Acting Chief Financial Officer position. Pay at risk has been allocated to each position based on the performance agreement relating to each position.

o. Incumbent held the position of Executive Vice President and Acting Executive Lead for Quality and Service Improvement until May 31, 2011 at which time the position was abolished as a result of restructuring and the incumbent was appointed to Executive Vice President and Chief Medical Officer. There was no additional compensation for the Executive Vice President and Chief Medical Officer position; however during the fiscal year the incumbent became eligible for pay at risk rather than other variable pay.

p. Position held by incumbent until May 30, 2011.

q. Incumbent held the position of Senior Vice President, Corporate Merger and Information Technology until November 30, 2011 at which time the incumbent was appointed to Senior Vice President and Chief Development Officer and became a direct report to the President and Chief Executive Officer. The Senior Vice President and Chief Development Officer position was established effective December 1, 2011 as a result of restructuring. The title for this position changed to Executive Vice President and Chief Development Officer effective January 10, 2012.

r. Incumbent appointed to position effective September 19, 2011 to September 18, 2016.

s. Incumbent held the position of Executive Vice President, Corporate Services until May 31, 2011 at which time the incumbent was appointed to Acting Executive Vice President, People and Partners. The Executive Vice President, Corporate Services position was abolished and the Executive Vice President, People and Partners position was established effective June 1, 2011 as a result of restructuring. The incumbent received an additional 10% of the base salary for the Acting Executive Vice President, People and Partners position. The incumbent held this position until September 18, 2011 at which point the incumbent was appointed to Senior Vice President, Edmonton Zone. The position of Senior Vice President, Edmonton Zone is not a direct report to the President and Chief Executive Officer. Pay at risk has been calculated based on 50% of the year end results of the Executive Vice President, People and Partners performance agreement and 50% of the year end results for the Senior Vice President, Edmonton Zone performance agreement. The pay at risk disclosed is the pay at risk received for the Executive Vice President, People and Partners position.

t. Position held by incumbent until January 10, 2012. The incumbent received the salary and other accrued entitlements to the date of departure. The reported severance includes 12 months base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits, both in accordance with the incumbent's contract. Should the incumbent obtain alternate employment during the 12 month notice period, the monthly payments will cease and the incumbent will be paid a lump sum equal to one-half of any payments then remaining. The incumbent received a proportionate amount of pay at risk for the months worked within the fiscal year based on the prior year's pay at risk amount. In addition AHS reimbursed the incumbent for legal costs of $10. AHS will also make payment for the incumbent to attend an outplacement program for a maximum of 6 months.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

u. Incumbent held the position of Executive Vice President, Rural, Public and Community Health until May 31, 2011 at which time the position was abolished as a result of restructuring. The incumbent continued as an employee until August 31, 2011, but was not a direct report to the President and Chief Executive Officer during this time.

v. Incumbent held the position of Executive Vice President, Clinical Support Services until May 11, 2011 at which time the incumbent was appointed to Executive Vice President and Executive Transition Lead. The Executive Vice President, Clinical Support Services position was abolished and the Executive Vice President and Executive Transition Lead position was established effective May 11, 2011 as a result of restructuring. There was no change in compensation for the Executive Vice President and Executive Transition Lead position which was held by incumbent until February 24, 2012. The reported severance includes 18 months base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits, both in accordance with the incumbent's contract. The amount also includes a pay at risk entitlement of $99K related to the 18 month severance period, in accordance with an amendment to the incumbent's contract entered into in the current year. The incumbent received a proportionate amount of pay at risk for the months worked within the fiscal year based on the achievement of the incumbent's individual objectives as outlined in the current year's performance agreement.

w. Incumbent appointed to position effective April 25, 2011.

x. Position held by incumbent until April 24, 2011 at which point the incumbent was relieved of Chief of Staff, Board Office responsibilities. The position of Vice President, Community Relations is not a direct report to the President and Chief Executive Officer.

Termination Liabilities

y. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive a maximum severance pay for 12 months base salary at the rate in effect at the date of termination. The incumbent will also receive 15% of the severance in lieu of all other benefits.

z. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 12 months base salary. This severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

aa. The incumbent's termination benefits have not been predetermined.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

bb. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 12 months base salary at the rate in effect at the date of termination. Such severance will be paid in 12 equal monthly installments. The incumbent will also be paid 15% of the severance in lieu of all other benefits. Upon obtaining alternate employment, the incumbent is only entitled to receive one-half of the unpaid severance at that time.

cc. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to a maximum of 18 months base salary[(k)] and premium payments at the rate in effect at the date of termination. The incumbent will also be paid an amount up to 18 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

dd. SPP and SERP

Based on the provision of the applicable SPP and SERP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2011-2012 fiscal period:

Position	Benefit (not in thousands)	Frequency	Payment Terms
Executive VP, Strategy and Performance	$52,199	One-Time	Paid in 2011-2012
Executive VP, Rural, Public and Community Health from September 1, 2011 until December 31, 2011[(u)]	$4,292	Monthly	4 Months
Executive VP, Rural, Public and Community Health from January 1, 2012[(u)]	$4,309	Monthly	Indefinite
Executive VP and Executive Lead Transition	$47,546	Annually	3 Years

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET
FOR THE YEAR ENDED MARCH 31, 2012

	Original Financial Plan (Note 4)	Adjustments (Note 3)	Reclassifications	Reported Budget
Revenue				
Alberta Health and Wellness contributions				
Unrestricted ongoing	$ 9,582,000	$ -	$ 52,000	$ 9,634,000
Unrestricted deficit funding	-	-	-	-
Restricted	818,000	-	-	818,000
Other government contributions	105,000	(19,000)	27,000	113,000
Fees and charges	645,000	(193,000)	-	452,000
Ancillary operations	117,000	-	-	117,000
Donations	30,000	-	-	30,000
Investment and other income	307,000	-	(70,000)	237,000
Amortization of external capital contributions	370,000	-	-	370,000
TOTAL REVENUE	11,974,000	(212,000)	9,000	11,771,000
Expenses				
Inpatient acute nursing services	2,823,000	(10,000)	(84,000)	2,729,000
Emergency and other outpatient services	1,350,000	7,000	(83,000)	1,274,000
Facility-based continuing care services	935,000	(19,000)	(2,000)	914,000
Ambulance services	372,000	-	7,000	379,000
Community-based care	881,000	(4,000)	106,000	983,000
Home care	445,000	-	(8,000)	437,000
Diagnostic and therapeutic services	2,025,000	12,000	(26,000)	2,011,000
Promotion, prevention and protection services	312,000	-	32,000	344,000
Research and education	230,000	-	(24,000)	206,000
Administration	324,000	(7,000)	75,000	392,000
Information technology	424,000	-	5,000	429,000
Support services	1,675,000	(191,000)	(10,000)	1,474,000
Amortization of facilities and improvements	198,000	-	21,000	219,000
TOTAL EXPENSES	11,994,000	(212,000)	9,000	11,791,000
Operating surplus (deficiency) of revenue over expenses	$ (20,000)	$ -	$ -	$ (20,000)
Expenses by object				
Salaries and benefits	$ 6,212,000	$ -	$ 103,000	$ 6,315,000
Contracts with health service providers	2,166,000	(212,000)	154,000	2,108,000
Contracts under the Heath Care Protective Act	18,000	-	1,000	19,000
Drugs and gases	386,000	-	(24,000)	362,000
Medical and surgical supplies	354,000	-	(20,000)	334,000
Other contracted services	1,218,000	-	(153,000)	1,065,000
Other	1,145,000	-	(52,000)	1,093,000
Amortization	495,000	-	-	495,000
TOTAL EXPENSES BY OBJECT	$ 11,994,000	$ (212,000)	$ 9,000	$ 11,791,000

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF RESTATEMENTS FOR THE YEAR ENDED MARCH 31, 2011

Consolidated Statement of Operations

	As Previously Reported	Long-term care Adjustment (Note 3(a))	Full cost Adjustment (Note 3(b))	Reclassifications (Note 3(d))	As Restated
Revenue					
Alberta Health and Wellness contributions					
Unrestricted ongoing	$ 9,037,311	$ -	$ (459)	$ -	$ 9,036,852
Unrestricted deficit funding	527,235	-	-	-	527,235
Restricted	747,830	-	-	-	747,830
Other government contributions	100,893	(3,552)	(12,206)	16,670	101,805
Fees and charges	621,481	-	(194,423)	-	427,058
Ancillary operations	112,367	-	-	-	112,367
Donations	28,574	-	-	-	28,574
Investment and other income	292,119	-	(240)	(16,670)	275,209
Amortization of external capital contributions	364,181	-	-	-	364,181
TOTAL REVENUE	11,831,991	(3,552)	(207,328)	-	11,621,111
Expenses					
Inpatient acute nursing services	2,584,209	-	(5,682)	(10,841)	2,567,686
Emergency and other outpatient services	1,220,870	-	(1,053)	(3,409)	1,216,408
Facility-based continuing care services	844,753	(1,801)	(13,996)	612	829,568
Ambulance services	343,034	-	-	9,373	352,407
Community-based care	800,256	(1,751)	(203)	(537)	797,765
Home care	402,375	-	-	(227)	402,148
Diagnostic and therapeutic services	1,861,589	-	(4,321)	(1,744)	1,855,524
Promotion, prevention and protection services	289,508	-	56	(251)	289,313
Research and education	214,253	-	181	(7,411)	207,023
Administration	307,342	-	(5,666)	2,549	304,225
Information technology	387,655	-	(7)	-	387,648
Support services	1,521,754	-	(176,637)	11,886	1,357,003
Amortization of facilities and improvements	198,238	-	-	-	198,238
TOTAL EXPENSES	10,975,836	(3,552)	(207,328)	-	10,764,956
Operating surplus (deficiency) of revenue over expenses	$ 856,155	$ -	$ -	$ -	$ 856,155

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF RESTATEMENTS (continued)
FOR THE YEAR ENDED MARCH 31, 2011

Consolidated Statement of Financial Position

	As Previously Reported	Long-term care Adjustment (Note 3(a))	Full cost Adjustment (Note 3(b))	Reclassifications (Note 3(d))	As Restated
ASSETS					
Current:					
Cash and cash equivalents	$ 1,721,465	$ -	$ -	$ (957,322)	$ 764,143
Investments	-	-	-	957,322	957,322
Accounts receivable	201,293	-	-	-	201,293
Contributions receivable from Alberta Health and Wellness	200,313	-	-	-	200,313
Inventories	99,097	-	-	-	99,097
Prepaid expenses	61,646	(2,700)	-	-	58,946
	2,283,814	(2,700)	-	-	2,281,114
Non-current cash and investments	599,335	-	-	-	599,335
Capital contributions receivable from Alberta Health and Wellness	11,476	-	-	-	11,476
Capital assets	6,707,464	-	-	-	6,707,464
Other assets	214,546	(130,953)	-	12,511	96,104
TOTAL ASSETS	$ 9,816,635	$ (133,653)	$ -	$ 12,511	$ 9,695,493
LIABILITIES AND NET ASSETS					
Current:					
Accounts payable and accrued liabilities	$ 1,136,937	$ -	$ -	$ -	$ 1,136,937
Accrued vacation pay	385,525	-	-	-	385,525
Deferred contributions	595,292	-	-	12,329	607,621
Current portion of long-term debt	153,799	-	-	-	153,799
	2,271,553	-	-	12,329	2,283,882
Deferred contributions	163,725	(151,396)	-	(12,329)	-
Deferred capital contributions	541,856	-	-	-	541,856
Long-term debt	182,500	-	-	-	182,500
Unamortized external capital contributions	5,598,973	-	-	-	5,598,973
Other liabilities	97,454	34,575	-	12,511	144,540
	8,856,061	(116,821)	-	12,511	8,751,751
Net assets:					
Accumulated surplus	115,741	(16,832)	-	-	98,909
Accumulated net unrealized gains (losses) on investments	(9,110)	-	-	-	(9,110)
Other internally restricted net assets	66,722	-	-	-	66,722
Internally restricted net assets invested in capital assets	777,071	-	-	-	777,071
Endowments	10,150	-	-	-	10,150
	960,574	(16,832)	-	-	943,742
TOTAL LIABILITIES AND NET ASSETS	$ 9,816,635	$ (133,653)	$ -	$ 12,511	$ 9,695,493

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF RESTATEMENTS (continued)
FOR THE YEAR ENDED MARCH 31, 2011

Consolidated Statement of Cash Flows

	As Previously Reported	Long-term care Adjustment (Note 3(a))	Full cost Adjustment (Note 3(b))	Reclassifications (Note 3(d))	As Restated
Operating activities:					
Operating surplus (deficiency) of revenue over expenses	$ 856,155	$ -	$ -	$ -	$ 856,155
Non-cash transactions:					
Amortization expense	470,511	-	-	-	470,511
Amortized external capital contributions	(364,606)	-	-	-	(364,606)
Other	(2,503)	(2,698)	-	52,706	47,505
Changes in non-cash working capital	(2,169)	2,698	-	(738,403)	(737,874)
Cash generated from (used by) operating activities	957,388	-	-	(685,697)	271,691
Cash generated from (used by) investing activities	(417,807)	-	-	(52,706)	(470,513)
Cash generated from financing activities	204,668	-	-	-	204,668
Net increase in current cash and cash equivalents	744,249	-	-	(738,403)	5,846
Current cash and cash equivalents, beginning of year	977,216	-	-	(218,919)	758,297
Current cash and cash equivalents, end of year	$ 1,721,465	$ -	$ -	$ (957,322)	$ 764,143

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF RESTATEMENTS (continued)
FOR THE YEAR ENDED MARCH 31, 2011

Consolidated Schedule of Expenses by Object

	As Previously Reported	Long-term care Adjustment (Note 3(a))	Full cost Adjustment (Note 3(b))	Reclassifications (Note 3(d))	As Restated
Salaries and benefits	$ 5,667,428	$ -	$ -	$ -	$ 5,667,428
Contracts with health service providers	1,958,269	-	(207,328)	130,569	1,881,510
Contracts under the Heath Care Protective Act	19,308	-	-	-	19,308
Drugs and gases	361,468	-	-	-	361,468
Medical and surgical supplies	330,132	-	-	-	330,132
Other contracted services	1,112,310	-	-	(137,954)	974,356
Other	1,056,410	(3,552)	-	7,385	1,060,243
Amortization	470,511	-	-	-	470,511
TOTAL EXPENSES BY OBJECT	$ 10,975,836	$ (3,552)	$ (207,328)	$ -	$ 10,764,956

Appendix

I. SURGICAL CONTRACTS

II. LIST OF AHS FUNDED FACILITIES

Surgical Contracts

NON-HOSPITAL SURGICAL FACILITY CONTRACTS UNDER THE HEALTH CARE PROTECTION ACT (ALBERTA)

Alberta Health Services contracts with multiple non-hospital surgical facilities (NHSF) to provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery, orthopedic and pregnancy terminations. The use of NHSFs enables AHS to obtain quality services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms.

Alberta Health Services determines if the contract is appropriate by assessing sustainability of the public system, access to services, patient safety, appropriateness, effectiveness, cost and public benefit. Contracts with NHSFs provide increased choice of service provider for patients and supplement the resources available in hospitals, while providing good value for public dollars.

The following table summarizes the contracts by service area for 2011-12.

SERVICE AREA	NUMBER OF OPERATORS	NUMBER OF PROCEDURES PERFORMED
Dermatology *(Only in Edmonton Zone)*	1	40
Ophthalmology	11	20,357
Oral and Maxillofacial Surgery	17	2,455
Otolaryngology (ENT) *(Only in Edmonton Zone)*	1	87
Plastic Surgery *(Only in Edmonton Zone)*	2	708
Pregnancy Termination	2	10,888

Surgical contracts with NHSFs are in the Calgary and Edmonton Zones; there are no surgical contracts with NHSFs in the South, Central or North Zones.

List of AHS Funded Facilities

Legend:

Facility Type Abbreviation	Description	Explanation
Addiction	Addiction Treatment Beds/Spaces	Facilities with beds and mats for clients with substance use and gambling problems. Includes detoxification, nursing care, assessment, counseling and treatment. Direct services provided by AHS as well as funded and contracted services. Also includes beds for PChAD (Protection of Children Abusing Drugs) program clients and residential beds funded through the Safe Communities Initiative.
Comm MH	Community Mental Health Beds/Spaces	Mental health support home programs, Canadian Mental Health Association community beds and other mental health community beds/spaces.
Psych	Stand-alone Psychiatric Facilities	Stand-alone psychiatric facilities: 1. Alberta Hospital Edmonton (Edmonton) 2. Centennial Centre for Mental Health and Brain Injury (CCMHBI) (Ponoka) 3. Claresholm Centre for Mental Health and Addictions (Claresholm) 4. Southern Alberta Forensic Psychiatric Centre (Calgary) 5. Villa Caritas (Edmonton)
Hospital	Hospital	Acute Care Hospitals where active treatment is provided. ED reflects facilities with Emergency Departments and no acute care beds. CA reflects Cancer Care facilities. OP reflects facilities providing ambulatory services.
Subacute	Subacute in an Auxiliary Hospital	Subacute care provided in Auxiliary Hospital for the purpose of receiving convalescent and/or rehabilitation services, where it is anticipated that they will achieve their functional potential, to enable them to improve their health status and to successfully return to the community.
LTC	Long Term Care	Long term care is provided in nursing homes and auxiliary hospitals. It is reserved for those with unpredictable and complex health needs, usually multiple chronic and/or unstable medical conditions. Long-term care includes health and personal care services, such as 24-hour nursing care provided by registered nurses or licensed practical nurses.
Palliative	Palliative	Facilities where a designated program or bed for the purpose of receiving palliative care services including end of life and symptom alleviation not in an acute care facility. Include community hospice beds.
SL	Supportive Living	Supportive living include comprehensive services such as the availability of 24-hour nursing care (levels 3 or 4). Supportive Living 4-Dementia (SL4D) is also available for those individuals living with moderate to severe dementia or cognitive impairment. Albertans accessing supportive living services generally reside in lodges, retirement communities, or supportive living centres.
Cancer	Cancer Care	Cancer Care Services include: Assessments and examinations, supportive care, pain management, prescription of cancer-related medications, education, resource and support counseling and referrals to other cancer centres.
CACC	Community Ambulatory Care Centre	A community ambulatory care centre (CACC) is a community-based service delivery site (non-hospital setting) primarily engaged in the provision of ambulatory care diagnostic and treatment services. This includes typically scheduled primary care for clients who do not require hospital outpatient emergency care or inpatient treatment.
UCC/AACC	Urgent Care Centre/ Advanced Ambulatory Care Centre	Urgent Care Centre (UCC) and Advanced Ambulatory Care Centres (AACC) provide assessment, diagnostic and treatment services for unscheduled patients who require immediate medical attention for injuries/illness that require human and technical resources more intensive than what is available in physicians office.

South Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Bassano Health Centre	*	Bassano				X		X					
Crowsnest Pass Health Centre	*	Blairmore				X		X					
York Creek Lodge		Blairmore								X			
Bow Island Health Centre	*	Bow Island				X		X					
Pleasant View Lodge		Bow Island								X			
Brooks Health Centre	*	Brooks				X		X					
Orchard Manor		Brooks								X			
Sunrise Gardens		Brooks								X			
Cardston Health Centre	*	Cardston				X		X					
Chinook Lodge		Cardston								X			
Good Samaritan Society, Lee Crest		Cardston								X			
Coaldale Health Centre	*	Coaldale				X		X					
Sunny South Lodge		Coaldale								X			
Extendicare Fort MacLeod		Fort MacLeod						X					
Foothills Detox Centre		Fort MacLeod	X										
Fort MacLeod Health Centre	*	Fort MacLeod				X							
Pioneer Lodge		Fort MacLeod								X			
Chinook Regional Hospital	*	Lethbridge				X					X		
Columbia House Lethbridge		Lethbridge								X			
Edith Cavell Care Centre		Lethbridge						X					
Extendicare, Fairmont Park		Lethbridge								X			
Golden Acres		Lethbridge								X			
Good Samaritan Park Meadows Village		Lethbridge								X			
Good Samaritan West Highlands		Lethbridge								X			
Legacy Lodge		Lethbridge								X			
South Country Treatment Centre		Lethbridge	X										
Southern Alcare Manor		Lethbridge	X										
St Michael's Health Centre		Lethbridge					X	X	X				
St Michael's Health Centre - St. Therese Villa		Lethbridge								X			
Youth Residential Services	*	Lethbridge	X										
Good Samaritan Garden Vista		Magrath								X			

South Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Magrath Health Centre	*	Magrath										X	
Club Sierra		Medicine Hat						X					
Cypress View Foundation		Medicine Hat								X			
Good Samaritan South Ridge Village		Medicine Hat						X		X			
Leisure Way		Medicine Hat								X			
Meadow Lands		Medicine Hat								X			
Medicine Hat Regional Hospital	*	Medicine Hat				X					X		
Riverview Care Centre		Medicine Hat						X					
Sunnyside Care Centre		Medicine Hat						X		X			
Wellington Retirement Residence		Medicine Hat								X			
The Valleyview		Medicine Hat						X		X			
Milk River Health Centre	*	Milk River						X					
Prairie Rose Lodge		Milk River								X			
Big Country Hospital	*	Oyen				X		X					
Piyami Health Care	*	Picture Butte										X	
Piyami Lodge		Picture Butte								X			
Piyami Place		Picture Butte								X			
Good Samaritan Pincher Creek Vista Village		Pincher Creek								X			
Pincher Creek Health Centre	*	Pincher Creek				X		X					
Good Samaritan Prairie Ridge		Raymond								X			
Raymond Health Centre		Raymond				X		X					
Clearview Lodge		Taber								X			
Good Samaritan, Linden View		Taber								X			
Taber Health Centre	*	Taber				X		X					

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Airdrie Health Centre	*	Airdrie											X
Bethany Care Centre Airdrie		Airdrie						X					
Mineral Springs Hospital		Banff				X		X					
Oilfields General Hospital	*	Black Diamond				X		X					
Agape Manor Hospice		Calgary							X				
Alberta Children's Hospital	*	Calgary				X							
Alpha House		Calgary	X										
Approved Homes - Mental Health		Calgary		X									
Aspen Family and Community Network (Eating Disorder Clinic)		Calgary		X									
Aventa Addiction Treatment for Women		Calgary	X										
Bethany Care Centre		Calgary						X					
Bethany Harvest Hills		Calgary						X					
Beverly Centre - Glenmore		Calgary						X					
Beverly Centre - Lake Midnapore		Calgary						X					
Bow Crest Care Centre		Calgary						X					
Bow View Manor		Calgary						X					
Canadian Mental Health Association		Calgary		X									
Canadian Mental Health Association (Hamilton House)		Calgary		X									
Carewest Colonel Belcher Care Centre	*	Calgary						X		X			
Carewest Dr. Vernon Fanning Centre	*	Calgary					X	X					
Carewest Garrison Green	*	Calgary						X					
Carewest George Boyack	*	Calgary						X					
Carewest Glenmore Park	*	Calgary					X						
Carewest Nickle House	*	Calgary								X			
Carewest Royal Park	*	Calgary						X					
Carewest Sarcee	*	Calgary					X	X	X				
Carewest Signal Pointe	*	Calgary						X					
Centre of Hope - Salvation Army		Calgary	X										
Clifton Manor (Brenda Stafford Foundation)		Calgary						X					

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)		Calgary		X									
Eau Claire Retirement Residence		Calgary								X			
Edgemont Retirement Residence		Calgary								X			
Enviros Wilderness School Association		Calgary		X									
Extendicare Cedars Villa		Calgary						X					
Extendicare Hillcrest		Calgary						X					
Father Lacombe Care Centre		Calgary						X					
Foothills Medical Centre	*	Calgary				X							
Fresh Start Recovery Centre		Calgary	X										
Glamorgan Care Centre		Calgary						X					
Hospice Calgary - Rosedale Hospice		Calgary							X				
Hull Homes Detox/PChaD		Calgary	X										
Intercare Brentwood Care Centre		Calgary						X					
Intercare Chinook Care Centre		Calgary						X	X				
Intercare Millrise Care Centre		Calgary						X					
Intercare Southwood Care Centre		Calgary						X	X				
Jackson Willan Seniors' Residence		Calgary								X			
Mayfair Care Centre		Calgary						X					
McKenzie Towne Continuing Care Centre		Calgary						X					
McKenzie Towne Retirement Residence		Calgary								X			
Millrise Place		Calgary								X			
Monterey Place		Calgary								X			
Mount Royal Care Centre		Calgary						X					
Newport Harbour Care Centre		Calgary						X					
Oxford House		Calgary	X										
Personal Care Homes - Continuing Care		Calgary								X			
Peter Lougheed Centre	*	Calgary				X							
Prince of Peace Harbour		Calgary								X			
Prince of Peace Manor		Calgary								X			
Recovery Acres		Calgary	X										
Renfrew Recovery Centre	*	Calgary	X										
Richmond Road Diagnostic & Treatment Centre	*	Calgary				OP							

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Rockyview General Hospital	*	Calgary				X							
Rotary Flames House	*	Calgary							X				
Scenic Acres Retirement Residence		Calgary								X			
Sheldon M. Chumir Health Centre	*	Calgary											X
South Calgary Health Centre	*	Calgary											X
Southern Alberta Foresenic Psychiatric Centre	*	Calgary			X								
Sunridge Medical Gallery	*	Calgary										X	
Sunrise Native Addiction Services Society		Calgary	X										
Tom Baker Cancer Centre	*	Calgary									X		
Wentworth Manor/The Residence and Court		Calgary						X		X			
Whitehorn Village Retirement Community		Calgary								X			
Wing Kei Care Centre		Calgary						X					
Woods Homes Stabilization Beds		Calgary								X			
Youth Detoxification and Residential Services	*	Calgary	X										
Youville Women's Residence		Calgary	X										
Canmore General Hospital	*	Canmore				X		X			X		
Little Bow Continuing Care Centre	*	Carmangay						X					
Claresholm Centre for Mental Health and Addictions	*	Claresholm			X								
Claresholm General Hospital	*	Claresholm				X							
Lander Treatment Centre	*	Claresholm	X										
Willow Creek Continuing Care Centre	*	Claresholm						X					
Bethany Care Centre - Cochrane		Cochrane						X					
Cochrane Community Health Centre	*	Cochrane											X
Aspen Ridge Lodge		Didsbury								X			
Didsbury District Health Services	*	Didsbury				X		X					
High River General Hospital	*	High River				X		X			X		
Silver Willow Lodge		Nanton								X			
Foothils Country Hospice		Okotoks							X				
Okotoks Health and Wellness Centre	*	Okotoks											X
Strathmore District Health Services	*	Strathmore				X		X					
Extendicare Vulcan		Vulcan						X					
Vulcan Community Health Centre	*	Vulcan				X		X					

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Bashaw Care Centre	*	Bashaw					X	X				X	
Bentley Care Centre	*	Bentley						X				X	
Breton Health Centre	*	Breton						X	X			X	
Bethany Meadows		Camrose						X		X			
Faith House		Camrose								X			
Louise Jensen Care Centre		Camrose						X					
Memory Lane		Camrose						X		X			
Rosehaven Care Centre		Camrose						X					
St Mary's Hospital		Camrose				X					X		
Sunrise Village		Camrose								X			
Viewpoint		Camrose								X			
Castor Community Health Centre	*	Castor										X	
Our Lady of the Rosary Hospital		Castor				X		X					
Consort Community Health Centre	*	Consort										X	
Consort Hospital and Care Centre	*	Consort				X		X					
Coronation Community Health Centre	*	Coronation										X	
Coronation Hospital and Care Centre	*	Coronation				X		X		X			
Daysland Health Centre	*	Daysland				X							
Providence Place		Daysland								X			
Drayton Valley Community Health Centre	*	Drayton Valley										X	
Drayton Valley Hospital and Care Centre	*	Drayton Valley				X		X			X		
Serenity House	*	Drayton Valley								X			
Drumheller Health Centre	*	Drumheller				X		X			X		
Grace House		Drumheller	X										
Hillview Lodge		Drumheller								X			
Eckville Community Health Centre	*	Eckville										X	
Eckville Manor House		Eckville								X			
Elnora Community Health Centre	*	Elnora										X	
Galahad Care Centre	*	Galahad						X					
Hanna Health Centre	*	Hanna				X		X					
Hardisty Health Centre	*	Hardisty				X		X					

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Innisfail Health Centre	*	Innisfail				X		X					
Sunset Manor - Legacy West / Innisfail Country Manor		Innisfail								X			
Islay Assisted Living	*	Islay								X			
Killam Health Care Centre		Killam				X		X					
Lacombe Community Health Centre	*	Lacombe										X	
Lacombe Hospital and Care Centre	*	Lacombe				X		X					
Manor at Royal Oak Village (Good Samaritan Society)		Lacombe								X			
Lamont Health Care Centre		Lamont				X		X					
Linden Nursing Home		Linden						X					
Points West Living Lloydminster		Lloydminister								X			
Dr Cooke Extended Care Centre		Lloydminster						X					
Slim Thorpe Recovery Centre		Lloydminster	X										
Lloydminster Hospital		Lloydminster, Sask.				X					X		
Mannville Care Centre	*	Mannville						X				X	
Mary Immaculate Health Centre		Mundare										X	
Mary Immaculate Hospital		Mundare						X					
Eagle View Lodge		Myrnam								X			
Enviros Wilderness School (Shunda Creek)		Nordegg	X										
Olds Community Health Centre	*	Olds										X	
Olds Hospital and Care Centre	*	Olds				X		X					
Sunrise Village Olds (Continuum HealthCare Corp)		Olds								X			
Centennial Centre for Mental Health and Brain Injury	*	Ponoka			X								
Northcott Care Centre		Ponoka						X					
Ponoka Community Health Centre	*	Ponoka										X	
Ponoka Hospital and Care Centre	*	Ponoka				X		X					
Sunrise Village Ponoka (Continuum HealthCare Corp)		Ponoka								X			
Provost Health Centre	*	Provost				X		X		X			
Addiction Counselling & Prevention Services	*	Red Deer	X										
Bethany CollegeSide (Red Deer)		Red Deer						X					
Extendicare Michener Hill		Red Deer						X		X			

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Kentwood Place	*	Red Deer		X									
Pines Lodge - Piper Creek Foundation		Red Deer								X			
Red Deer 49th Street Community Health Centre	*	Red Deer										X	
Red Deer Bremner Avenue Community Health Centre	*	Red Deer										X	
Red Deer Hospice		Red Deer							X				
Red Deer Regional Hospital Centre	*	Red Deer				X					X		
Safe Harbour Society		Red Deer	X										
Symphony Seniors Living at Aspen Ridge		Red Deer								X			
West Park Lodge		Red Deer								X			
Rimbey Community Health Centre	*	Rimbey										X	
Rimbey Hospital and Care Centre	*	Rimbey				X		X					
Clearwater Centre (Rocky Mountain House)		Rocky Mountain House						X		X			
Rocky Mountain House Health Centre	*	Rocky Mountain House				X							
Stettler Community Health Centre	*	Stettler										X	
Stettler Hospital and Care Centre	*	Stettler				X		X					
Sundre Community Health Centre	*	Sundre										X	
Sundre Hospital and Care Centre	*	Sundre				X		X					
Bethany Sylvan Lake		Sylvan Lake						X		X			
Sylvan Lake Community Health Centre	*	Sylvan Lake										X	
Chateau Three Hills		Three Hills								X			
Three Hills Health Centre	*	Three Hills				X		X					
Tofield Health Centre	*	Tofield				X		X					
St. Mary's Health Care Centre		Trochu						X				X	
Two Hills Health Centre	*	Two Hills				X		X					
Century Park Points West Living		Vegreville								X			
Heritage House		Vegreville								X			
St Joseph's General Hospital		Vegreville				X							
St. Michael's Manor Vegreville		Vegreville								X			
Vegreville Care Centre	*	Vegreville						X					
Vermilion Health Centre	*	Vermilion				X		X					
Vermilion Valley Lodge		Vermilion								X			

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Viking Extendicare		Viking						X					
Viking Health Centre	*	Viking				X							
Points West Living Wainwright		Wainwright								X			
Wainwright Health Centre	*	Wainwright				X		X					
Good Shepherd Lutheran Home		Wetaskiwin								X			
Peace Hills Lodge		Wetaskiwin								X			
Sunrise Village Wetaskiwin (Continuum HealthCare Corp)		Wetaskiwin								X			
Wetaskiwin Community Health Centre	*	Wetaskiwin										X	
Wetaskiwin Hospital and Care Centre	*	Wetaskiwin				X		X					
Winfield Community Health Centre	*	Winfield										X	

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Kipohtakawmik Elders Lodge		Alexander Reserve								X			
Place Beausejour		Beaumont								X			
Devon General Hospital	*	Devon				X		X					
Addiction Recovery Centre	*	Edmonton	X										
Alberta Hospital Edmonton	*	Edmonton			X								
All Seniors Care Rutherford		Edmonton								X			
Allen Gray Continuing Care Centre		Edmonton						X					
Allendale House		Edmonton		X									
Anderson Hall		Edmonton		X									
CASA House		Edmonton		X									
CapitalCare Dickinsfield	*	Edmonton						X					
CapitalCare Dickinsfield Duplexes (Young Adult Program)	*	Edmonton								X			
CapitalCare Grandview	*	Edmonton					X	X					
CapitalCare Laurier House	*	Edmonton								X			
CapitalCare Lynnwood	*	Edmonton						X					
CapitalCare McConnell Place North	*	Edmonton								X			
CapitalCare McConnell Place West	*	Edmonton								X			
CapitalCare Norwood	*	Edmonton					X	X	X				
Christensen Community - Devonshire Manor		Edmonton								X			
Christensen Community - Garneau Hall		Edmonton								X			
Cross Cancer Institute	*	Edmonton				X					X		
Devonshire Care Centre		Edmonton						X					
E4C Mc Cauley Apartment		Edmonton		X									
E4C Meadows Lodge		Edmonton		X									
E4C Our Lodge		Edmonton		X									
Edmonton Chinatown Care Centre		Edmonton						X		X			
Edmonton General Continuing Care Centre		Edmonton					X	X	X				
Edmonton People In Need #4 - Batoma House		Edmonton								X			

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Emmanuel Home		Edmonton								X			
Excel Society - Balwin Villa		Edmonton								X			
Excel Society - Grand Manor		Edmonton								X			
Extendicare Holyrood		Edmonton						X					
Extendicare Somerset		Edmonton						X					
George Spady Centre Society		Edmonton	X										
Glastonbury Village		Edmonton								X			
Glenrose Rehabilitation Hospital	*	Edmonton				X							
Good Samaritan Dr. Gerald Zetter Care Centre		Edmonton					X	X					
Good Samaritan Millwoods Centre		Edmonton						X					
Good Samaritan Southgate Care Centre		Edmonton						X					
Good Samaritan Wedman House		Edmonton								X			
Grey Nuns Community Hospital		Edmonton				X							
Hardisty Care Centre Ltd.		Edmonton						X					
Health First Strathcona	*	Edmonton											X
Henwood Treatment Centre	*	Edmonton	X										
House Next Door #1,2,3		Edmonton		X									
Innovative Housing - Gravelle		Edmonton								X			
Innovative Housing - Villa Marguerite		Edmonton								X			
Jasper Place Continuing Care Centre		Edmonton						X					
Jellinek House		Edmonton	X										
Jubilee Lodge Nursing Home		Edmonton						X					
Lifestyle Options - Riverbend		Edmonton								X			
Lifestyle Options - Terra Losa		Edmonton								X			
McDougall House		Edmonton	X										
Miller Crossing Care Centre		Edmonton						X					
Misericordia Community Hospital		Edmonton				X							
Northeast Community Health Centre	*	Edmonton				ED							
Our House		Edmonton	X										
Recovery Acres Edmonton		Edmonton	X										
Revera Retirement LP - Churchill Retirement Community		Edmonton								X			

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Revera Retirement LP - Riverbend Retirement Residence		Edmonton								X			
Rosary Hill		Edmonton		X									
Rosedale at Griesbach		Edmonton								X			
Rosedale Estates		Edmonton								X			
Royal Alexandra Hospital	*	Edmonton				X							
Salvation Army Grace Manor		Edmonton								X			
Salvation Army Stepping Stone Supportive Residence		Edmonton								X			
Shepherd's Care Foundation - Ashbourne		Edmonton								X			
Shepherd's Care Foundation - Golden Age Manor		Edmonton								X			
Shepherd's Care Foundation - Greenfield		Edmonton								X			
Shepherd's Care Foundation - Millwoods Shepherd's Care Centre		Edmonton						X					
Shepherd's Care Foundation - Shepherd's Garden		Edmonton								X			
Shepherd's Care Foundation, Kensington Village Continuing Care Centre		Edmonton						X		X			
South Terrace Continuing Care Centre		Edmonton						X					
St. Joseph's Auxiliary Hospital		Edmonton						X	X				
St. Michael's Long Term Care Centre		Edmonton					X	X					
St. Thomas Health Centre		Edmonton								X			
Stollery Children's Hospital	*	Edmonton				X							
The Dianne and Irving Kipnes Centre for Veterans	*	Edmonton						X					
The Waterford of Summerlea (Retirement Home)		Edmonton								X			
Touchmark at Wedgewood		Edmonton						X					
University of Alberta Hospital	*	Edmonton				X							
Venta Care Centre		Edmonton						X					
Villa Caritas		Edmonton			X								
Wild Rose Cottage (Chartwell Seniors Housing)		Edmonton								X			
Youth Detoxification and Residential Services	*	Edmonton	X										
Good Samaritan Pembina Village		Evansburg						X					
Fort Saskatchewan Health Centre	*	Fort Saskatchewan				X							
Rivercrest Care Centre		Fort Saskatchewan						X					
Extendicare Leduc		Leduc						X					

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Leduc Community Hospital	*	Leduc				X		X					
Lifestyle Options - Leduc		Leduc								X			
Salem Manor Nursing Home		Leduc						X					
Aspen House	*	Morinville								X			
Redwater Health Centre	*	Redwater				X		X					
All Seniors Care Summerwood Village		Sherwood Park								X			
Capital Care Strathcona	*	Sherwood Park						X		X			
Country Cottage - Chartwell		Sherwood Park								X			
Sherwood Park Care Centre		Sherwood Park						X					
Good Samaritan Spruce Grove Centre		Spruce Grove								X			
Christensen Community - Citadel Mews West		St. Albert								X			
Citadel Care Centre		St. Albert						X					
Poundmaker's Lodge Treatment Centre		St. Albert	X										
Rosedale St Albert		St. Albert								X			
Sturgeon Community Hospital	*	St. Albert				X							
Youville Auxiliary Hospital (Grey Nuns) of St. Albert		St. Albert						X	X				
Good Samaritan George Hennig Place		Stony Plain								X			
Good Samaritan Stony Plain Care Centre		Stony Plain						X		X			
WestView Health Centre - Stony Plain	*	Stony Plain				X		X					
Family Care Homes		Various								X			
Mental Health Care Homes		Various		X									
Personal Care Homes		Various								X			
West Country Hearth		Villeneuve								X			

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Athabasca Healthcare Centre	*	Athabasca				X		X					
Extendicare Athabasca		Athabasca						X					
Barrhead Healthcare Centre	*	Barrhead				X					X		
Dr. W.R. Keir - Barrhead Continuing Care Centre	*	Barrhead						X					
Mental Health Spaces		Barrhead		X									
Shepherd's Care Barrhead		Barrhead								X			
Beaverlodge Municipal Hospital	*	Beaverlodge				X							
Bonnyville Healthcare Centre		Bonnyville				X		X			X		
Bonnyville Indian Metis Rehabilitation Centre		Bonnyville	X										
Extendicare Bonnyville		Bonnyville						X					
Boyle Healthcare Centre	*	Boyle				X							
Cold Lake Healthcare Centre	*	Cold Lake				X		X					
Ridge Valley Seniors Assistance Society		Crooked Creek								X			
Wabasca/Desmarais Healthcare Centre	*	Desmarais				X							
Edson Healthcare Centre	*	Edson				X		X					
Parkland Lodge		Edson								X			
Elk Point Healthcare Centre	*	Elk Point				X		X					
Fairview Health Complex	*	Fairview				X		X	X				
Northern Lights Regional Health Centre	*	Fort McMurray				X		X			X		
Pastew Place Detox Centre		Fort McMurray	X										
St. Theresa General Hospital	*	Fort Vermilion				X		X					
Fox Creek Healthcare Centre	*	Fox Creek				X							
Glendon Community Health Services	*	Glendon										X	
Grande Cache Community Health Complex	*	Grande Cache				X		X					
Grande Prairie Care Centre		Grande Prairie						X					
NAC Business & Industry Clinic	*	Grande Prairie	X										
Northern Addiction Centre	*	Grande Prairie	X										
PointsWest Living		Grande Prairie						X		X			
Queen Elizabeth II Hospital	*	Grande Prairie				X	X	X			X		
The Gardens at Emerald Park - Point West Living		Grande Prairie								X			
YouthDetoxification Services	*	Grande Prairie	X										
Grimshaw/Berwyn & District Community Health Centre	*	Grimshaw				ED		X	X				

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Action North Recovery Centre		High Level	X										
Northwest Health Centre	*	High Level				X		X					
High Prairie Health Complex	*	High Prairie				X							
J. B. Wood Continuing Care Centre	*	High Prairie						X					
Metis Indian Town Alcohol Association (MITAA Centre)		High Prairie	X										
Hinton Healthcare Centre	*	Hinton				X					X		
Mountain View Centre		Hinton								X			
Hythe Continuing Care Centre	*	Hythe						X					
Evergreen Alpine - Jasper		Jasper								X			
Seton - Jasper Healthcare Centre	*	Jasper				X							
Heimstaed Lodge		La Crete								X			
La Crete Continuing Care Centre	*	La Crete						X	X				
La Crete Health Centre	*	La Crete											X
William J. Cadzow - Lac La Biche Healthcare Centre	*	Lac La Biche				X		X					
Manning Community Health Centre	*	Manning				X		X					
Extendicare Mayerthorpe		Mayerthorpe						X					
Mayerthorpe Healthcare Centre	*	Mayerthorpe				X		X					
Manoir du Lac		McLennan						X		X			
Sacred Heart Community Health Centre	*	McLennan				X							
Chateau Lac St. Anne		Onoway								X			
Onoway Community Health Services	*	Onoway										X	
Peace River Community Health Centre	*	Peace River				X		X			X		
Radway Continuing Care Centre	*	Radway						X					
Rainbow Lake Health Centre	*	Rainbow Lake										X	
Slave Lake Healthcare Centre	*	Slave Lake				X		X					
George McDougall - Smoky Lake Healthcare Centre	*	Smoky Lake				X		X					
Smoky Lake Continuing Care Centre	*	Smoky Lake						X					
Central Peace Health Complex	*	Spirit River				X		X					
Extendicare St. Paul		St Paul						X					
St. Therese - St. Paul Healthcare Centre	*	St Paul				X		X					
St. Paul Abilities Network		St. Paul		X									

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Subacute	LTC	Palliative	SL	Cancer	CACC	UCC
Swan Hills Healthcare Centre	*	Swan Hills				X							
Thorhild Community Health Services	*	Thorhild										X	
Valleyview Health Centre	*	Valleyview				X		X					
Our Lady's Community Health Services	*	Vilna										X	
Vilna Villa		Vilna								X			
Smithfield Lodge		Westlock								X			
Westlock Healthcare Centre	*	Westlock				X		X					
Spruceview Lodge		Whitecourt								X			
Whitecourt Healthcare Centre	*	Whitecourt				X							

Alberta Health
Services